

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9623

Item 7 File #2220 9-24-57 et

CERTIFICATE OF DEATH

09596

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck.				c. LENGTH OF STAY IN 1b 1 Year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Nursing Home				e. STREET ADDRESS Good Hope Road,			
4. NAME OF DECEASED (Type or print) First RICHARD Middle H. Last ADAMS				4. DATE OF DEATH Month Sept. Day 15 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1878	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78		IF UNDER 24 HRS. Hours 78 Min. 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Maryland.			
11. BIRTHPLACE (State or foreign country) Maryland.				12. CITIZEN OF WHAT COUNTRY? Maryland.			
13. FATHER'S NAME George Adams				14. MOTHER'S MAIDEN NAME Martha Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Malinda Dorsey			
17. INFORMANT Spencerville, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 610X DUE TO Prostatic Hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral Prostatectomy (c) Bilateral Prostatectomy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 weeks 2 years 2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/13/57 to 9/15/57 , 19 57 , that I last saw the deceased alive on 9/13/57 , 19 57 , and that death occurred at 2:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird				DATE SIGNED 9/17/57			
PHYSICIAN'S NAME (Type) J. W. Bird				ADDRESS (Street, city or town, state) Spencerville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORY Good Hope,		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				24. REGISTRAR'S SIGNATURE Francis Potter			

RECEIVED
SEP 20 1957
BUREAU V. S.

SEP 20 1957

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
9592 Item 2 See: Birth Cert. et
CERTIFICATE OF DEATH

09597
 Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
c. LENGTH OF STAY IN 1b <u>51 min</u>			d. STREET ADDRESS <u>8654 Piney Branch Road</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Infant Girl Albritten</u>			4. DATE OF DEATH <u>September 15, 1957</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 15, 1957</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. AGE (In years last birthday) <u>51</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Baylus Richard Albritten Jr.</u>			14. MOTHER'S MAIDEN NAME <u>Barbara Jane Lovell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Deformities</u> <u>759.3</u> DUE TO <u>(Hydrocephalus, diagnosis)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Raymond Chinn</u> M.D. PHYSICIAN'S NAME (Type) <u>Raymond Chinn, M. D. 925 Pershing Dr. Silver Spring, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. New M.L.</u>		ADDRESS <u>Wash. San. & Hosp.</u>		24a. REC'D BY REGISTRAR DATE <u>9/19/57</u>	24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075282 x 12

CERTIFICATE OF DEATH

A FURTHER STATEMENT OF HEALTH - ATTACHED TO

Form 100-10

BUREAU V. 2

SEP 23 1957

RECEIVED

9624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 146 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
f. STREET ADDRESS 2134 Newport Place, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Norman Middle Pacshal Last Anderson		4. DATE OF DEATH Month September Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abner Anderson		14. MOTHER'S MAIDEN NAME Carrie Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-07-1101	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphosarcoma, Chronic pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH 3-4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 12, 1957 , to September 5, 1957 , that I last saw the deceased alive on September 5, 1957 , and that death occurred at 10:32 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Kurt W. Kohn M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 9/5/57 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) KURT W. KOHN, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-11-1957	22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	22d. LOCATION (City, town, or county) (State) 4001-Suitland Rd. Md
23. FUNERAL DIRECTOR'S SIGNATURE William Spangler		24a. REC'D BY REGISTRAR 524-8-5th NE SE DATE SEP 10 1957	
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

DIAGNOSIS

DATE OF EXAMINATION

PLACE OF EXAMINATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

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BUREAU V. 1

SEP 10 1957

RECEIVED

9593

CERTIFICATE OF DEATH

Reg. Dist. No.

723

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 11 Hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 9713 Dilston Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Helen Margaret Appich		4. DATE OF DEATH Month Day Year Sept. 15 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-84
9. AGE (In years last birthday) 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) D. C.
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME John McCormack	
14. MOTHER'S MAIDEN NAME (unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, congestive 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerotic cardiovascular disease. DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **May**, 1957, to **15 Sept**, 1957, that I last saw the deceased alive on **15 Sept**, 1957, and that death occurred at **1:25 AM**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **9/15/57** DATE SIGNED
ACTUAL SIGNATURE **Ernest E. Harmon** M.D. **9301 Colesville RD. Silver Spring**
PHYSICIAN'S NAME (Type) **Ernest E. Harmon M.D.**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/17/1957	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR SEP 17 1957	24b. REGISTRAR'S SIGNATURE J. H. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 17 1957

RECEIVED

Item 18 Film 222 11-15-57
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09600
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>X2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4801 North Lane</u>				d. STREET ADDRESS <u>4801 North Lane</u>			
3. NAME OF DECEASED (Type or print) <u>MAMIE</u> First <u>TOTTEN</u> Middle <u>AULT</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24, 1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u>24</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Marjorie A. Donnally- 7820 Glenbrook Rd. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Deferred</u> <u>Coronary Insufficiency</u> DUE TO (b) <u>Myocardial hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead sitting in chair</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Bruchant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 20, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
MEDICAL EXAMINER'S OFFICE
STATE OF NEW YORK

BUREAU V. S.

SEP 23 1957

RECEIVED

9626

CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Jane</u> Middle <u>Austin</u>		4. DATE OF DEATH <u>September 11-1937</u> Month <u>September</u> Day <u>11</u> Year <u>1937</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July-17-1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Boyd, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Henry Austin</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Ann Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John Harrington Austin, Boyd, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral accident March 3, 1936</u> DUE TO <u>High Arterial tension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March-3-1936</u> to <u>Sept-11-1937</u> , that I last saw the deceased alive on <u>Sept-7-1937</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Miller, M.D.</u>		DATE SIGNED <u>7-Brooks Ave.,</u>	
PHYSICIAN'S NAME (Type) <u>William C. Miller, M.D.</u>		<u>Faithersburg, Md.</u>	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-13-37</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	22d. LOCATION (City, town, or nearby) (State) <u>Barnesville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James C. Gartner, Faithersburg, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>	
DATE <u>9/13/37</u>		<u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP. 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9594

09602

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE FLORIDA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TITUSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wakefield Nursing Home				d. STREET ADDRESS 413 PALM AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle ACTON Last Ayars				4. DATE OF DEATH Month Sept. Day 18, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/71	9. AGE (In years and birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Salem, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Acton				14. MOTHER'S MAIDEN NAME Mary Andrews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Mr. James Ayars, 1904 Erie St. Hyattsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Disturbance DUE TO 475A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia DUE TO 30day.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 8-5 , 1957, to 9-18 , 1957, that I last saw the deceased alive on 9-17 , 1957, and that death occurred at 7:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W B Wardrop M.D.		ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, Md.		DATE SIGNED 9/18/57			
PHYSICIAN'S NAME (Type) William B. Wardrop, M.D.		ADDRESS 837 Bonifant St. Silver Spring, Md.		24. REC'D BY REGISTRAR DATE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/21/57		22c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEMETERY		22d. LOCATION (City, town, or county) (State) SILVER SPRING, NEW JERSEY	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				24b. REGISTRAR'S SIGNATURE J. N. Todd			

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SEP 20 1957
BUREAU V. S.

9627

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY MONTG MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 8yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE Goldthorne AYRES				4. DATE OF DEATH Month Day Year September 21 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 15-1873	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher. Retired,				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Aldoph Knabe				14. MOTHER'S MAIDEN NAME Elizabeth Christman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Asbury Methodist Home Records. As 1D				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 454.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONITIS DUE TO (c) RHEUMATOID ARTHRITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1-4 1956 , to 9-21 1957 , that I last saw the deceased alive on 9-18 1957 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sarah E Glover M.D. 4208 AnThony S.T. Kensington 8-21-57							
ACTUAL SIGNATURE Sarah E Glover							
PHYSICIAN'S NAME (Type) Sarah E Glover							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9-24-57		Prospect Hill		Washington. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				ADDRESS Gaithersburg. Md.		24a. REC'D BY REGISTRAR Sept 24-57	
				24b. REGISTRAR'S SIGNATURE Abraham Y. Goble			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SEP 26 1957

BUREAU V. S.

9628

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery Co. General Hospital		d. STREET ADDRESS 11209 Upton Drive	
3. NAME OF DECEASED (Type or print) First Paul Middle P. Last Baker		4. DATE OF DEATH Month September Day 10 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/00
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Agent		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Baker		14. MOTHER'S MAIDEN NAME Mary Catherine Glaize	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 705-12-2981	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 7 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/10 , 19 57 , to 9/10 , 19 57 , that I last saw the deceased alive on 9/10 , 19 57 , and that death occurred at 9:25A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Silver Spring, Md 9/10/57			
ACTUAL SIGNATURE A. D. Bonheant		M.D. Saul S. Spring, M.D.	
PHYSICIAN'S NAME (Type) A. D. Bonheant			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/12/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Strasburg, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24. REC'D BY REGISTRAR SEP 13 1957	
ADDRESS Silver Spring, Md		25. REGISTRAR'S SIGNATURE Gertrude L. Loring	

MEDICAL CERTIFICATION

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RECEIVED
SEP 11 1954

RECEIVED
SEP 11 1954
BUREAU

CERTIFICATE OF DEATH

Reg. Dist. No.

9629

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Conservation Gardens Nursing Home</u>		d. STREET ADDRESS <u>1223 Michigan Ave. N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Nelly (Nellie)</u> First <u>Baltimore</u> Last		4. DATE OF DEATH <u>Sept. 20th</u> 19 <u>57</u> Month <u>Sept.</u> Day <u>20th</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>79</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>H.Y.</u>	9c. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.Y.</u>	10c. AGE (In years last birthday) <u>79</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. H. Clague</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>125 Michigan Ave. N.E. Wash. D.C.</u>	
17. INFORMANT <u>Richard Clague</u>		18. ADDRESS <u>125 Michigan Ave. N.E. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>None</u> (b) <u>None</u> (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>19 57</u> Hour <u>2:50</u> p. m.	20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Washington D.C.</u> (County) <u>D.C.</u> (State) <u>D.C.</u>
21. I certify that I attended the deceased from <u>Sept 19 57</u> to <u>Sept 20 57</u> that I last saw the deceased alive on <u>Sept 19 57</u> and that death occurred at <u>2:50</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew F. Ruland</u>		ADDRESS (Street, city or town, state) <u>301 E. 1st St. N.E.</u>	
PHYSICIAN'S NAME (Type) <u>Andrew F. Ruland</u>		DATE SIGNED <u>SEP 27 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Methodist Ch.</u>	22d. LOCATION (City, town, or county) <u>Potomac Md.</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel S. Searles</u>		24a. REC'D BY REGISTRAR <u>SEP 27 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Kelley</u>	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

SEP 27 1957

RECEIVED
MAY 1957

BUREAU V. S.

SEP 5 1957

RECEIVED

9630

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rothschild</u>				c. LENGTH OF STAY IN 1b <u>6 1/2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
f. STREET ADDRESS <u>521 Reall Ave.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George</u> <u>Washington</u> <u>Peamer</u>				4. DATE OF DEATH Month Day Year <u>Sept.</u> <u>5</u> <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6 1876</u>	9. AGE (In years last birthday) <u>81</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bookkeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Rockville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Americ</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO <u>Unknown</u>				17. INFORMANT <u>George Peamer</u> Address <u>521 Reall Ave. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Central embolism</u> DUE TO							<u>1 hr</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							(b) <u>Central Thrombosis</u> DUE TO
(c) <u>Central arteriosclerosis</u>							<u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>8/26</u> , 19 <u>57</u> , to <u>9/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/5</u> , 19 <u>57</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.				<u>Rockville Md</u> <u>9/5/57</u>			
PHYSICIAN'S NAME (Type)				<u>Stephen N. Jones</u>			
22a. BURIAL, CREMATION, or other disposal	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)				
<u>BURIAL</u>	<u>9-9-1957</u>	<u>CEDAR HILL</u>	<u>SUITLAND, MD.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lili Grambsos</u>				ADDRESS <u>1401 Wisconsin Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 6 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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RECEIVED

1957

BURMAN V. S.

9631
CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Rest Home		d. STREET ADDRESS 251 W. 87th St. Apt. #75	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Chantiles Last Belasco		4. DATE OF DEATH Month Sept. Day 30 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12 1/30/1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Clerk-Franklin		10b. KIND OF BUSINESS OR INDUSTRY 7th Bank, N.Y. City	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Chamtilis		14. MOTHER'S MAIDEN NAME Tasia Sioris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Philip Chantiles-5422 1st Pl. N.W.		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Congestive heart failure DUE TO Core pulmonale Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 week one year 6 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 10, 1957 to Sept 30, 1957 that I last saw the deceased alive on Sept. 30, 1957 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5600 N.H. Ave. Wash., D.C. DATE SIGNED 9/30/57			
ACTUAL SIGNATURE SAMUEL M BAGEANT M.D. 5600 N.H. Ave. Wash., D.C.		PHYSICIAN'S NAME (Type) SAMUEL M BAGEANT	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/3/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE: OCT 4 1957 24b. REGISTRAR'S SIGNATURE W. H. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOT 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000

CERTIFICATE OF DEATH

9632

09609

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution- Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg,				c. LENGTH OF STAY in 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First GRANT Middle U. Last BELL				4. DATE OF DEATH Month Sept. Day 28 Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1901	9. AGE (In years last birthday) yrs. 56	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Grant Bell				14. MOTHER'S MAIDEN NAME Elizabeth Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Ida Mae Bell				Address Dickerson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Rt. Lung DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH one month 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January, 1950 to 28 Sept. , 1957, that I last saw the deceased alive on 27 Sept. , 1957, and that death occurred at 3:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith				ADDRESS (Street, city or town, state) BARNESVILLE, Md.			
PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.				DATE SIGNED 28 Sept 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/57		22c. NAME OF CEMETERY OR CREMATORY Martinsburg,		22d. LOCATION (City, town, or county) (State) Martinsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24. REC'D BY REGISTRAR 1957	
25. REGISTRAR'S SIGNATURE Charles Egin							

RECEIVED

8 1957

BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9633

CERTIFICATE OF DEATH

09610

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 10 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 206 Summit Ave.				d. STREET ADDRESS 206 Summit Ave.			
3. NAME OF DECEASED (Type or print) NETTIE First V Middle BEST Last				4. DATE OF DEATH Month Sept Day 10 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25 1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George W. Cashell				14. MOTHER'S MAIDEN NAME Catherine A. Hobbs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) #####		16. SOCIAL SECURITY NO (If yes, give first or third of service) #####		17. INFORMANT Lawrence Best		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 Month, Day, Year 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 9-1-57 , 19 57 , to 9-10 , 19 57 , that I last saw the deceased alive on 9-10 , 19 57 , and that death occurred at 6 P M, from the causes and on the date stated above							
ACTUAL SIGNATURE F.J. Broschart				ADDRESS (Street, city or town, state) 8 Burrall Ave Gaithersburg, Maryland			
PHYSICIAN'S NAME (Type) F.J. Broschart				DATE SIGNED 9-12-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 13 57		22c. NAME OF CEMETERY OR CREMATORY St Johns		22d. LOCATION (City, town, or county) (State) Olney Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonville, Md.		24a. REC'D BY REGISTRAR DATE Sept 11-57	
				24b. REGISTRAR'S SIGNATURE Alfred L. Gode			

BUREAU V. S.

SEP 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9634

CERTIFICATE OF DEATH

Reg. Dist. No.

09611/4

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1203 Highland Drive</i>				d. STREET ADDRESS <i>1203 Highland Drive</i>			
3. NAME OF DECEASED (Type or print) <i>Thomas DeWitt Bittenbender</i>				4. DATE OF DEATH <i>Sept 6 1957</i>			
5 SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 25, 1898</i>	
9. AGE (In years, lost birthday) <i>61</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Motion Picture Operator</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>James B. Bittenbender</i>				14. MOTHER'S MAIDEN NAME <i>Agnes Sitzenburger</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>578-05-6663</i>		17. INFORMANT <i>Mrs Pearl Bittenbender</i> Address <i>(Same)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO <i>Chronic Glomerular Nephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Nephrotic Syndrome</i> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Nov 2</i> , 19 <i>50</i> , to <i>Sept 6</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Sept 6</i> , 19 <i>57</i> , and that death occurred at <i>5:10</i> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.				ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring Md</i>			
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>				DATE SIGNED <i>9/10/57</i>			
22a. BURIAL, CREMATION, or REMOVAL <i>burial</i>		22b. DATE THEREOF <i>9/9/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. N.W.</i> ADDRESS <i>Wash. D.C.</i>				24a. REC'D BY REGISTRAR <i>16 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>	

BUREAU V. S.

SEP 17 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9635

CERTIFICATE OF DEATH

Reg. Dist. No.

09612 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 7 yrs. 1 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged				d. STREET ADDRESS 2104 St. Paul St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Fannie Middle L. Last Blades				4. DATE OF DEATH Month Sept Day 9 Year 1957			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1867	
9. AGE (in years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John L. Blades				14. MOTHER'S MAIDEN NAME Elizabeth F. Gayle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Asbury Methodist Home, Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prolonged hypertension DUE TO (c) malnutrition						INTERVAL BETWEEN ONSET AND DEATH 9-1-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2-1 , 19 26 , to 9-9 , 19 22 , that I last saw the deceased alive on 9-4 , 19 27 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4205 Park Thruway St Kensington Md DATE SIGNED 9-9-57							
ACTUAL SIGNATURE Sarah E. Glover M.D.							
PHYSICIAN'S NAME (Type) Sarah E. Glover							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons Inc. Baltimore Md.				24a. REC'D BY REGISTRAR SEP 11 1957		24b. REGISTRAR'S SIGNATURE Alfred G. Cook	

RECEIVED

APR 11 1947

RECEIVED

9636

CERTIFICATE OF DEATH

09613

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3134 18th St., North	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dora Middle Tappy Last BLANKENSHIP		4. DATE OF DEATH Month September Day 28 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 August 1903
9. AGE (In years last birthday) yrs 54		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles TAPPY		14. MOTHER'S MAIDEN NAME Mary LOHR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Husband) Thomas P. BLANKENSHIP (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, rt. lung DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma, metastatic DUE TO 1 month (c) Carcinoma, rt. breast 2+ yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Ca. of skin, axillary & mediastinal lymph nodes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I of Part II of item 18) pleuræ, pleurodynia, liver, kidneys & uterus.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 Sept. 19 57 to 28 Sept. 19 57 , that I last saw the deceased alive on 28 Sept. 19 57 , and that death occurred at 6:15P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. B. Ingram M.D.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-30-57	
PHYSICIAN'S NAME (Type) Wm. B. Ingram, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 19-1-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home		24a. REC'D BY REGISTRAR 2847 Wilson Blvd. Arlington, Va.	
24b. REGISTRAR'S SIGNATURE May E. Parrelly		DATE 9-30-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

CT 1 1957

RECEIVED

9637

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>518 Philadelphia Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Adeline</u> Last <u>Bradburn</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 20, 1863</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>20</u> Days <u>10</u> Hours <u>19</u> Min <u>57</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Benjamin Longley</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Scheible</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Adeline B. Matthews</u> Address <u>518 Phil. Ave. Park, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia & atelectasis, rt. lung</u> <u>401.2</u> DUE TO (b) <u>Past op - mid right</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>amputation Rt for vascular occlusion</u> 21 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis, Scurvy</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/31</u> , 19 <u>57</u> , to <u>9/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>57</u> , and that death occurred at <u>2:50</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace W. Bernston</u> M.D.				ADDRESS (Street, city or town, State) <u>10511 Summit Ave</u> DATE SIGNED <u>9/20/57</u>			
PHYSICIAN NAME (Type) <u>Horace W. Bernston</u>				<u>Runnington, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>9/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Stable Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. K. [unclear]</u>				ADDRESS <u>5732 [unclear]</u>		24a. REC'D BY REGISTRAR <u>[unclear]</u> DATE <u>9-24-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar.

BUREAU V. S.

SEP 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9638

CERTIFICATE OF DEATH

09615

Item 1. Film G221. 10/3/57 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY M			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena Nursing Home				d. STREET ADDRESS 740 Silver Spring Ave			
3. NAME OF DECEASED (Type or print) Robert Bragazzi				4. DATE OF DEATH Sept. 24 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-73	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Worker		10b. KIND OF BUSINESS OR INDUSTRY Hotels		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Leon Bacek Address 740 Silver Spring Ave			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular Fibrillation DUE TO (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 weeks 10 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1956 , to September 24, 1957 , that I last saw the deceased alive on September 22, 1957 , and that death occurred at 5:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED September 24, 1957							
ACTUAL SIGNATURE Harry J. Kicherer M.D.				SIGNATURE September 24, 1957			
PHYSICIAN'S NAME (Type) Harry J. Kicherer, M.D.				ADDRESS 10620 Georgia Ave., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-57		22c. NAME OF CEMETERY OR CREMATORY St. O. Church		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Neus Funeral Home ADDRESS 4812 Faune Rd				24a. REC'D BY REGISTRAR SEP 27 1957		24b. REGISTRAR'S SIGNATURE Francis Ball	

BUREAU V. R.

SEP 27 1957

RECEIVED

9639

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Olney				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation				d. STREET ADDRESS Hyattstown Mill Road			
3. NAME OF DECEASED (Type or print) JOSEPHINE R. BRANDENBURG				4. DATE OF DEATH Sept. 7 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1885	
9. AGE (In years last birthday) yrs 72		10. UNDER 1 YEAR Months 0 Days 6 Hours Min 		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME John A. Baker				14. MOTHER'S MAIDEN NAME Amia Pollock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT David J. Brandenburg-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bronchitis, Bilat. 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Smoking DUE TO (c) Arteriosclerosis, Gen'l.				INTERVAL BETWEEN ONSET AND DEATH 4 days years 0 0			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 1955 to Sept. 7, 1957 , that I last saw the deceased alive on Sept. 6, 1957 , and that death occurred at 8:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Jack Schumacher M.D. 9-9-57							
ACTUAL SIGNATURE Jack Schumacher							
PHYSICIAN'S NAME (Type) Jack Schumacher-Medical Bldg., Gaithersburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/11/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 10/19/57		24b. REG. STRAR'S SIGNATURE Centauride Lovley	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

10 1957

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9612
23

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>5 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7123 723 Maple Ave.</u>		d. STREET ADDRESS <u>7123 723 Maple Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Max</u> Middle <u>Braver</u> Last <u></u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired hat maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213 18 6344</u>	
17. INFORMANT <u>Carrie Braver (wife)</u>		Address <u>Same as item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974X</u> DUE TO <u>hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hung self by neck in bath room of his home</u>	
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>9/25/57</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 28, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walter, 254 Carroll St NW D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 27 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walter</u>			

BUREAU V. S.

SEP 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09618

9640

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TB 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital		e. STREET ADDRESS 5061 Bradley Blvd.	
3. NAME OF DECEASED (Type or print) First Thelma Middle Flora Last Brouse		4. DATE OF DEATH Month September Day 1 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/00
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 57 Days 1 Hours 1 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville Groves		14. MOTHER'S MAIDEN NAME Ada Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 9040	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cedens - Carcinoma left Breast DUE TO 110X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Melanotic, Internal. DUE TO 6 mos (c) Pathologic Fracture right Hip DUE TO 1 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9040			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall fracture right hip	
20c. TIME OF INJURY Month, Day, Year Hour 1:30 a. m. 19 57 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chen Chong		20f. (City or town) Montgomery (County) (State)	
21. I certify that I attended the deceased from 8/28/57 , 19 57 , to 9/1/57 , 19 57 , that I last saw the deceased alive on 8/30 , 19 57 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird, M. D.		ADDRESS (Street, city or town, state) Sandy Spring, Md.	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		DATE SIGNED 9/3/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-3-57	
22c. NAME OF CEMETERY OR CREMATORY Remington		22d. LOCATION (City, town, or county) (State) Remington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home 4812 Gadsden Rd		24a. REC'D BY REGISTRAR SEP 5 1957	
24b. REGISTRAR'S SIGNATURE Gertrude Landry			

RECEIVED
SEP 5 1957
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4-11-57

9597

CERTIFICATE OF DEATH

09619

Reg. Dist. No.

YK3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Steven Burke</u>				4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1893</u>	9. AGE (In years last birthday) <u>63 yrs</u>	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't worker</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Thomas Burke</u>				14. MOTHER'S MAIDEN NAME <u>Hester Lincoln</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Chart of Pt.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u>							<u>Thrs</u>
DUE TO (b) <u>Essential hypertension</u>							<u>10 yrs</u>
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept. 2</u> , 19 <u>57</u> , to <u>Sept. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 2</u> , 19 <u>57</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>				ADDRESS (Street, city or town, state) <u>Washington Sanitarium</u>			
DATE SIGNED <u>September 3, 1957</u>							
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				24a. REC'D BY REGISTRAR <u>1400 Chapin St. N.W. WASH. D.C.</u>			
				24b. REGISTRAR'S SIGNATURE <u>J. Nelson Saddy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15-31-1843 03
HARRY 21041 BUKG

BUREAU V. E.

SEP 9 1957

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9641

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Catherine</u> Last <u>Butt</u>				4. DATE DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 12/1877</u>	9. AGE (In years, last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Frank Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Evelyn R. Clagett</u>		Address <u>Rockville, Md. 212 W. Mont. Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Coronary A.S. & D.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>24 hr.</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intestinal Obstruction & secondary anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/1</u> , 19 <u>57</u> , to <u>9/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>57</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville Md.</u> DATE SIGNED <u>9/20/57</u>			
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Thompson</u> ADDRESS				24a. REC'D BY REGISTRAR <u>9-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

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BUREAU V. S.

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... physician

... with certificate

CERTIFICATE OF DEATH

Reg. Dist. No.

216

09642

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairway Hills M.P.O. Wash. 16, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6209 Crathie Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Roscoe</u> Last <u>Cade</u>		4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/86</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>12</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>practice of law</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Bartholomew Cade</u>		14. MOTHER'S MAIDEN NAME <u>Anna Fillman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1918</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Helen C. Cade</u>		Address <u>6209 Crathie Lane Washington 16, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Heart Disease -</u> 5 yrs. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arterio Sclerosis - Brain softening</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>8 SEPT</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7 SEPT</u> , 19 <u>57</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		ADDRESS (Street, city or town, state) <u>7936 Georgetown Rd. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		DATE SIGNED <u>8 SEPT 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>9-9-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

SEP 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9643

CERTIFICATE OF DEATH

09622

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE M.D. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b 1 hr 40 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 9803 Parkwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GABRIELA Middle E. Last CALDWELL				4. DATE OF DEATH Month SEP. Day 30 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2, 1890		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY (RETIRED)			10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME P.W. ELLIS				14. MOTHER'S MAIDEN NAME LILLIE BELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address MRS. M. PTHA BROACH 9303 PARKWOOD R. BETHESDA, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema 1-0-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Congestive Heart Failure (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 10 hrs. 5-6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/1 , 19 56 to 9/30 , 19 57 , that I last saw the deceased alive on 9/30 , 19 57 , and that death occurred at 2:40 A.M. from the causes and on the date stated above							
ACTUAL SIGNATURE Seymour Greenbaum M.D.				ADDRESS (Street, city or town, state) 9300 Ewing Dr. Bethesda, Md.		DATE SIGNED 9/30/57	
PHYSICIAN'S NAME (Type) SEYMOUR GREENBAUM, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 10/3/57		22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		22d. LOCATION (City, town, or county) (State) Columbus, Mississippi	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 10-1-57	
				24b. REGISTRAR'S SIGNATURE Jessie M. Thompson			

BUREAU V. S.

OCT 9 1900



9644

CERTIFICATE OF DEATH

Reg. Dist. No. 215

Item 13 Film G 221 10-8-57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>7 Days</u>				d. STREET ADDRESS <u>2379 Rhode Island Ave., N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Ray</u> Last <u>CAMPBELL</u>				4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 September 1918</u>	9. AGE (In years last birthday) yrs. <u>38</u>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joe CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>Minnie B. WOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>(Wife) Mrs. Helen D. CAMPBELL (Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma with metastasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 Aug.</u> , 19 <u>57</u> , to <u>3 Sept.</u> , 19 <u>57</u> that I last saw the deceased alive on <u>3 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>6:20 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Douglas R. Koth</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>				9-3-57			
PHYSICIAN'S NAME (Type) <u>Douglas R. Koth, LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. J. Chambers</u> ADDRESS <u>Chambers, 1400 Chapin St., N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>Mary E. Parrelly</u> 24b. REGISTRAR'S SIGNATURE DATE <u>9-3-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 5 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9645

CERTIFICATE OF DEATH

09624

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>124 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Cole</u> Last <u>Carroll</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>19 57</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>April 14, 1926</u>	
9. AGE (n years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Traffic Engineering</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13 FATHER'S NAME <u>Charles L. Carroll, Sr.</u>				14 MOTHER'S MAIDEN NAME <u>Alice Cole</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>Yes</u> (If yes, give war or dates of serv ce) <u>WW II</u>				16 SOCIAL SECURITY NO <u>214-20-5363</u>		17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC EPIDERMAL CELL CARCINOMA</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>10 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>57</u> , to <u>September 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>September 21</u> , 19 <u>57</u> , and that death occurred at <u>12:46 p. M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>The Clinical Center</u>				DATE SIGNED <u>9/22/57</u>			
ACTUAL SIGNATURE <u>Robert Weiger, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>ROBERT WEIGER, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balts National</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Rd. Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>				ADDRESS <u>-3818 Roland Ave</u>		24a REC'D BY REGISTRAR <u>P 25 1957</u>	
				24b REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

SEP 25 1957

RECEIVED

9598

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>				d. STREET ADDRESS <u>4817</u>			
3. NAME OF DECEASED (Type or print) <u>Paschal Ralph Chambers</u>				4. DATE OF DEATH <u>Sept. 12 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-88</u>	9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>J. William Chambers</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>hang?</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Chant</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>480.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Hypertension</u>						INTERVAL BETWEEN DEATH AND DEATH <u>12/2/57</u> <u>31/7/57</u> <u>1951</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb 23 1947</u> to <u>Sept 12 1957</u> , that I last saw the deceased alive on <u>Sept 12 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. I. Snouse</u>				ADDRESS (Street, city or town, state) <u>7030 Carroll Ave</u> DATE SIGNED <u>9/12/57</u>			
PHYSICIAN'S NAME (Type) <u>Ralph A. Chambers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph A. Chambers</u>				ADDRESS <u>Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>SEP 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page J should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

SEP 16 1957

RECEIVED

9599

CERTIFICATE OF DEATH

09626

Reg. Dist. No. 21-3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C. Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp</u>		d. STREET ADDRESS <u>7019 Georgia Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Earneſt alexander Cole</u>		4. DATE OF DEATH Month <u>9-</u> Day <u>7</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-96</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS Months <u>6</u> Days <u>7</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Guard - 4.5 Supreme Court.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Preston Cole</u>		14. MOTHER'S MAIDEN NAME <u>Frances McGowan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Records - + Daughter</u>	
17. INFORMANT <u>Records - + Daughter</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>8 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>Sept 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>57</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James C Mandes</u>		ADDRESS (Street, city or town, state) <u>1801 K ST N.W.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JAMES C MANDES</u>		<u>WASHINGTON, D.C.</u>	
22a. BURIAL, CREMATION, <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee F. Walters</u>		24a. REC'D BY REGISTRAR <u>17-5</u> DATE <u>9/10/57</u>	
24b. REGISTRAR'S SIGNATURE <u>17-5</u>		24c. REGISTRAR'S SIGNATURE <u>17-5</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 13 1967
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

0962716

9646

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		MARYLAND c. LENGTH OF STAY IN 1b 56 days		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d STREET ADDRESS 6700 Piney Branch Road, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle Ida Last Coleman		4. DATE OF DEATH Month September Day 22 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 2, 1908	9. AGE (In years last birthday) 49 yrs	IF UNDER 1 YEAR Months 49 Days 19 Hours 57 Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teletype Analyst		10b KIND OF BUSINESS OR INDUSTRY Electric Company		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Robert E. Coleman		14. MOTHER'S MAIDEN NAME Mary Edith Slack	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO 577-07-8631		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2.20 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from July 28 , 19 57 , to September 22 , 19 57 , that I last saw the deceased alive on September 22 , 19 57 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James C. Allen M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland 9/23/57					
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF Sept 24, 1957		22c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
22d LOCATION (City, town, or county) Washington		(State) D. C.			
23 FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		ADDRESS 254 Carroll St NW		24a REC'D BY REGISTRAR SEP 24 1957	
24b REGISTRAR'S SIGNATURE Bessie Thompson					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 24 1957

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9647 CERTIFICATE OF DEATH

Reg. Dist. No. 096297

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 8 hrs, 10 min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				d. STREET ADDRESS Woodbine 06 X 2.5			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Cook				4. DATE OF DEATH Month September Day 3 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/3/57	
9. AGE (In years last birthday) yrs. 8		10. AGE (In years last birthday) yrs. 10		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Edward Cook				14. MOTHER'S MAIDEN NAME Martha Ann Lowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fetal Atelectasis DUE TO (c) Prematurity							INTERVAL BETWEEN ONSET AND DEATH 8 hours 8 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sep. 3, 19 57 , to Sep. 3, 19 57 , that I last saw the deceased alive on September 3, 19 57 , and that death occurred at 2:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md. DATE SIGNED SEP 6 1957							
ACTUAL SIGNATURE L. I. Leal				PHYSICIAN'S NAME (Type) L. I. Leal			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		9-4-1957		FAIRVIEW		CARROLL CO Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Wartz ADDRESS Winfield, Md.				24a. REC'D BY REGISTRAR SEP 6 1957		24b. REGISTRAR'S SIGNATURE Gertrude Fairley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION

SEP 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9648

Reg. Dist. No. 09622.16

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>5008 RUGBY AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGIE P. COOKE</u>				4. DATE OF DEATH Month Day Year <u>SEPT 22 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 21-1877</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>RICHMOND, VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>LEVI</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA A. WATSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>SON</u> <u>CL. PORTER III</u> Address <u>5008 RUGBY AVE. BETHESDA MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>2 YEARS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MAY 14</u> , 1957, to <u>SEPT. 12</u> , 1957, that I last saw the deceased alive on <u>SEPT. 22</u> , 1957, and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u>				ADDRESS (Street, city or town, state) <u>M.D. 5009 DEL RAY AVE. BETHESDA Md</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>				DATE SIGNED <u>9/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u>		22d. LOCATION (Cty., town, or county) (State) <u>Henrico County, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>9-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beanie M. Thompson</u>	

27

BUREAU V. S.

SEP 26 1971

RECEIVED

9649 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville	
c. LENGTH OF STAY IN 1b 26 days		d. STREET ADDRESS Spencersville Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Frances Middle Josephine Last Corbin		4. DATE OF DEATH Month September Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1916
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Henry Eichholz		14 MOTHER'S MAIDEN NAME Alvina Sommers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO 578-10-4229	
17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest HIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Failure DUE TO (c) Mitral Insufficiency			INTERVAL BETWEEN ONSET AND DEATH 5 m. 22 10 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Surgery.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 1, 1957 to September 27, 1957 , that I last saw the deceased alive on September 27, 1957 , and that death occurred at 1:17 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Waldhausen M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) John A. Waldhausen, M. D.		DATE SIGNED 9/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/1/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. DATE SEP 30 1957	24b. REGISTRAR'S SIGNATURE Basia Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. F.

1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9650

09631

Reg. Dist. No.

214

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b				c. STREET ADDRESS <u>2507 Kimberly St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>J.C. Penny Company 8656 Colesville Rd.</u>							
3. NAME OF DECEASED (Type or print) <u>Donald M. Couldren</u>		First Middle Last		4. DATE OF DEATH <u>September 3 19 57</u>		a. SEX OF DECEASED ON A F A M YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/28/13</u>	9. AGE (In years and birthday) <u>44</u> yrs	FUNDING YEAR IF UNDER 24 HR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harry Edward Couldren</u>				14. MOTHER'S MAIDEN NAME <u>Florence Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>184-09-1084</u>			
17. INFORMANT <u>Mrs. Grace Couldren, 2507 Kimberly St.</u>				Address <u>Silver Spring, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUT NOT TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				DATE SIGNED <u>9/3/57</u>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				M D CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter C. Humphrey</u>				24a. REC'D BY REGISTRAR <u>9/10/57</u> 24b. REGISTRAR'S SIGNATURE <u>Frances C. Miller</u>			

RECEIVED

SEP 13 1957

BUREAU V. S.

9617

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1211 Highwood Rd.				e. STREET ADDRESS 1211 Highwood Rd.			
3. NAME OF DECEASED (Type or print) CONSTANTINE First COUROUTIOTIS Middle Last				4. DATE OF DEATH Month Sept. Day 20, Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1889		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 8 Days 19 Hours Min. 	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook-retired			10b. KIND OF BUSINESS OR INDUSTRY employed		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Stephen Courouniotis				14. MOTHER'S MAIDEN NAME Antonia Angelitis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Rachel Courouniotis Address same as item 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction							12 hr
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) coronary thrombosis							24 hr
(c) coronary atherosclerosis							Relief
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
coronary thrombosis & st. hypertension							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from June 3, 1956 to Sept. 20, 1957 that I last saw the deceased alive on Sept. 20, 1957 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 9/24/57							
ACTUAL SIGNATURE Stephen N. Jones M.D.							
PHYSICIAN'S NAME (Type) STEPHEN N. JONES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Address Bethesda, Maryland				24a. REC'D BY REGISTRAR SEP 23 1957		24b. REGISTRAR'S SIGNATURE Lawell Krug	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

75

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09633

9651

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville 1-1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Cowburn</u> Last <u>Cowburn</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 7, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Manchester, England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>William Cowburn</u>		14. MOTHER'S MAIDEN NAME <u>Susan Wood</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. <u>037-15-7496</u>		17. INFORMANT <u>William A. Cowburn</u>		Address <u>9303 20th Ave W. Hyattsville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis, left coronary artery</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. si. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>August 1954</u> , to <u>Sept 29, 1957</u> , that I last saw the deceased alive on <u>Sept 29</u> , 1957, and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>8248 Georgia Avenue</u>				DATE SIGNED _____			
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D.				PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS MD Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince George Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>10-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

BUREAU V. S.

OCT 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09634

9652

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft Sanitarium & Hospital</u>				d. STREET ADDRESS <u>12308 Goodhill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Bernice</u> Middle <u>Alice</u> Last <u>Creed</u>				4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-1914</u>		9. AGE (In years last birthday) <u>42</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-typist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Police Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Vienna, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Thomas E. Crowell</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Cockrille</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Wheaton, Maryland</u> <u>Husband- Mr. Willie Creed 12308 Goodhill Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Edema</u> DUE TO <u>Acute Brain Syndrome with delirium tremens and convulsive seizures.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholism</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute degeneration of liver</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 7</u> , 19 <u>57</u> , to <u>Sept. 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 10</u> , 19 <u>57</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cedarcroft Sanitarium & Hospital</u> DATE SIGNED <u>Silver Spring, Maryland</u>							
ACTUAL SIGNATURE <u>Henry E. Andrén</u> M.D.				PHYSICIAN'S NAME (Type) <u>Henry E. Andrén, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 16 1957

RECEIVED

9600

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & Hospital				d. STREET ADDRESS 8702 Gilbert Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GRATTON - PAINTER CREGER				4. DATE OF DEATH 9 - 27 1957			
5. SEX Male	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/99	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Norfolk Western Railroad		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES CREGER				14. MOTHER'S MAIDEN NAME Ellis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO none		17. INFORMANT Douglas C. Cregar Address 8702 Gilbert Pl. Takoma Park			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490x Acute pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral lobar pneumonia DUE TO (c) 2 days				INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 25 , 19 57 , to Sept 27 , 19 57 , that I last saw the deceased alive on Sept 27 , 19 57 , and that death occurred at 9:30 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Raymond C. West				ADDRESS (Street, city or town, state) 7600 Carroll Ave Takoma Park, Md.			
PHYSICIAN'S NAME (Type) RAYMOND C. WEST							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR SEP 30 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 20 1901
BUREAU V. S.

9653

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4513 Sleaford Road				d. STREET ADDRESS 4513 Sleaford Road			
3. NAME OF DECEASED (Type or print) GEORGE J. DALEY				4. DATE OF DEATH Sept. 24, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mch 13, 1889	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 8 Days 11	IF UNDER 24 HRS Hours 11 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George J. Daley			14. MOTHER'S MAIDEN NAME Mary Allen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 579-03-9595		17. INFORMANT Mrs Teresa G. Daley-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 15 min. 2 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 to Sept. 24, 1957 , that I last saw the deceased alive on Sept. 24, 1957 , and that death occurred at 12:50 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo M. Curtis M.D.				ADDRESS (Street, city or town, state) 8218 Wisconsin Ave. Bethesda, Md.			
PHYSICIAN'S NAME (Type) Leo Curtis				DATE SIGNED 9/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 9/25/57		22c. NAME OF CEMETERY OR CREMATORY Elks		22d. LOCATION (City, town, or county) (State) Asbury Park, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 9-26-57		24b. REGISTRAR'S SIGNATURE Bessie M. Homan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. B.

SEP 20 1957

RECEIVED

9654

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>?</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Delaplane</u> Middle Last				4. DATE OF DEATH <u>9</u> Month <u>8</u> Day <u>1957</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24 - 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (retired) Pa. RR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hancock, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>James Delaplane</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>716-09-3524</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fever - E. coli - 3. veins Inflamed</u> 12 hrs 4-1X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility + Debility + Emaciation</u> 10 yrs. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-15-1954</u> to <u>9-7-1957</u> , that I last saw the deceased alive on <u>8-20-1957</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John B. Ziegler</u> M.D. <u>Olney Md</u> <u>9 Sept 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>9/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. THOMAS CEMETERY</u>	
				22d. LOCATION (City, town, or county) (State) <u>HANCOCK, MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>SILVER SPRING, MD</u>				24a. REC'D BY REGISTRAR <u>SEP 10 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Estelle L. Lewis</u>	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 10 1937

CHICAGO R. I.

9655

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Viers Mill Village				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Viers Mill Village			
c. LENGTH OF STAY IN lb 1 yr.				d. STREET ADDRESS 4205 Ivy Glen Rd.			
d. NAME OF HOSPITAL (If not 'n hospital, give street address) OR INSTITUTION 4205 Ivy Glen Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VINIA Middle BOGGS Last De WITT				4. DATE OF DEATH Month Sept. Day 27, Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 14, 1891	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 5 Days 13		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Andrew Boggs				14. MOTHER'S MAIDEN NAME ? Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Husband Herbert E. DeWitt		Address Item #2	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus 176X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4709 Montgomery Lane	
20f. (City or town) Montgomery				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from Jan 1952 to 9/27 1957, that I last saw the deceased alive on 8/31/57 and that death occurred at 1:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4709 Montgomery Lane, Bethesda, Md. DATE SIGNED 10-2-57							
ACTUAL SIGNATURE Paul D. Cantor				PHYSICIAN'S NAME (Type) PAUL D. CANTOR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/27/1957		22c. NAME OF CEMETERY OR CREMATORY Parklawn	
22d. LOCATION (City, town, or county) Montgomery Maryland				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR Laurell Kragtor		24b. REGISTRAR'S SIGNATURE Laurell Kragtor	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED

1957

RECEIVED
OCT 1957
COPIES

09632 216

9656

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7218 Chestnut Street				d. STREET ADDRESS 7218 Chestnut Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Donelon Last Donelon				4. DATE OF DEATH Month Sept Day 16 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1876		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81 Days 16 Hours 1957	IF UNDER 24 HRS. Months 81 Days 16 Hours 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, L & M Railroad				10b. KIND OF BUSINESS OR INDUSTRY Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Donelon				14. MOTHER'S MAIDEN NAME Mary Donelon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO no		17. INFORMANT John Donelon 7218 Chestnut St. C.C., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 1956, to Sept 15 , 1956, that I last saw the deceased alive on Sept 15 , 1956, and that death occurred at 3 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Wesley M. Oler				ADDRESS (Street, city or town, state) 1150 Gometicut Av. N.W. Wash. D.C.			
DATE SIGNED 9-16-57							
PHYSICIAN'S NAME (Type) Wesley M. Oler							
22a. BURIAL OR CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/16/57		22c. NAME OF CEMETERY OR CREMATORY New St. Joseph Cemetery		22d. LOCATION (City, town, or county) (State) Cincinnati, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				ADDRESS Wash. D.C.		24b. REGISTRAR'S SIGNATURE SEP 17 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED

SEP 17 1957

BUREAU V. S.

9657

CERTIFICATE OF DEATH

09640
Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 11 dyas	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery Co. General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Fletcher Last Dorsey		4. DATE OF DEATH Month September Day 20 Year 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min 54	IF UNDER 24 HRS Hours 54 Min 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Dorsey		14. MOTHER'S MAIDEN NAME Martha Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pyelonephritis DUE TO (c) Diabetes Mellitus - 2 yrs.			INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - 2 yrs.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 55 to September 20 , 19 58 , that I last saw the deceased alive on September 19, 1957 , and that death occurred at 4:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE C. S. Whitaker, M. D.		M.D.	
PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.		Clarksville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/22/57	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swarden		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE 2-1957
		24b. REGISTRAR'S SIGNATURE Arthur L. Loring	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 1 1917

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 217

9658

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gordon Apts.		d. STREET ADDRESS Gordon Apts.	
3. NAME OF DECEASED (Type or print) First Debra Middle MARIE Last Doss		4. DATE OF DEATH Month Sept Day 18 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 26, 1952
9. AGE (In years last birthday) 4 yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Florenteen Doss		14. MOTHER'S MAIDEN NAME Dorla Maxine Argenbright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Dorla Doss		Address Brookville, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Sarcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sarcinoma of eyelid, rt. (c) —			INTERVAL BETWEEN ONSET AND DEATH 1 day 5 mo. 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/17, 1957 to 9/18, 1957 , that I last saw the deceased alive on 9/17, 1957 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. Ligon, MD.		ADDRESS (Street, city or town, state) Sandy Spring, MD.	
PHYSICIAN'S NAME (Type) C. H. Ligon, MD.		DATE SIGNED 9/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/20/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24. REGISTRAR'S SIGNATURE Gertrude Lawler	

BUREAU V. S.

SEP 27 1907

RECEIVED

9601

CERTIFICATE OF DEATH

0964273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 17</u>			
c. LENGTH OF STAY in 1b <u>Since 8/27/57</u>				d. STREET ADDRESS <u>7909 GREENWOOD AVE.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>BALDWIN</u> Middle <u>DOTEN</u> Last				4. DATE OF DEATH <u>SEPTEMBER 14</u> 19 <u>57</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/12/02</u>	
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>DIST. of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO</u>			
13. FATHER'S NAME <u>CHARLES Otis DOTEN</u>				14. MOTHER'S MAIDEN NAME <u>ZARA BALDWIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-03-8188</u>		17. INFORMANT <u>SON</u> Address <u>7909 Greenwood AVE. TAKOMA PARK, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial Pneumonia - Rt. Upper Lobe</u> 1.0 DUE TO <u>Pyloric obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old Duodenal Ulcer</u> (c) <u>Old Duodenal Ulcer</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 18 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>OCT. 1953</u> , to <u>Sept 14, 1957</u> , that I last saw the deceased alive on <u>Sept 14, 1957</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D. <u>8248 GEORGIA AVE</u>				DATE SIGNED <u>9/14/57</u>			
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>				ADDRESS (Street, city or town, state) <u>SILVER SPRING, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Adair</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 17 1957

BUREAU V. S.

SEP 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09643

Reg. Dist. No. 215

9659

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN TB 13 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 2633 Garfield St., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle RUSSELL Last DOWLING				4. DATE OF DEATH Month September Day 1 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 April 1879	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred Bissell TALCOTT				14. MOTHER'S MAIDEN NAME Deretta Florence GOFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Daughter) Ellen Condon DOWLING (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA, left lung DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal failure with uremia						INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 August , 19 57 , to 1 Sept. , 19 57 , that I last saw the deceased alive on 1 September , 19 57 , and that death occurred at 9:25 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Wm. B. Ingram		U.S. Naval Hospital, Bethesda, Md. 9-3-57					
PHYSICIAN'S NAME (Type) Wm. B. INGRAM, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons, 1756 Penn. Ave., Washington, D.C.				24a. REC'D BY REGISTRAR DATE 9-3-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 4 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

09645723

9602

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. LENGTH OF STAY IN 1b <u>Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanit Hosp</u>				d. STREET ADDRESS <u>1830 University Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>Marguerite Mary Edwards</u>				4. DATE OF DEATH <u>Sept. 16 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 13 1897</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>16</u> Days <u>19</u> Hours <u>57</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Norton</u>		14. MOTHER'S MAIDEN NAME <u>Manie Berry</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Charlotte S. Marshall 8009 Eastern Ave. Silver Springs</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemic pneumonia</u> DUE TO <u>Suppurative bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bronchiectasis</u> (c) <u>2 wk plus</u> <u>2 wk plus</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>11</u> a. m. <u>11</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-2 1957</u> to <u>9-16 1957</u> , that I last saw the deceased alive on <u>9-16 1957</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>927 Rushing Rd</u>				DATE SIGNED <u>9-16-57</u>			
ACTUAL SIGNATURE <u>A.W. DANISH</u>				M.D. <u>Silver Springs Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>				ADDRESS <u>8434 Th. Ave Silver Springs, Md</u>		24a. REC'D BY REGISTRAR <u>SEP 18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Nelson</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 18 1957
DEAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9660

CERTIFICATE OF DEATH

09646

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>506 DEAN DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>DIANE</u> Middle <u>EMPLETON</u> Last <u>EMPLETON</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 26 - 1951</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min. <u>57</u>	11. IF UNDER 24 HRS. Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OHIO</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BERNARD E. EMPLETON</u>		14. MOTHER'S MAIDEN NAME <u>ANITA RICHARDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lymphocytic Leukemia</u> DUE TO (b) <u>18 mos.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>18 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5</u> 19 <u>56</u> , to <u>9-17</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9-17</u> 19 <u>57</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>6156 Montgomery Ave. Rockville, Md</u> DATE SIGNED <u>9/17/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			
22b. DATE THEREOF <u>9/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	
22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Pamphrey</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 9-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. 1

SEP 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>7139 Maple Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Patrick Jerome Etherson</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-19-87</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Packing Mgr.</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Robert Etherson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McIntyre</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1904</u>				16. SOCIAL SECURITY NO. <u>PT's Chart</u>			
17. INFORMANT <u>PT's Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gargene, early, rt. lower extremity</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Embolism, rt. common iliac artery</u> DUE TO (c) <u>Arteriosclerosis, lower aorta, with thrombosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old cystic neovasis, rt. cerebral hemisphere, due to arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>9/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>57</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7401 BLAIR Road NW</u>				DATE SIGNED <u>Wash. DC</u>			
ACTUAL SIGNATURE <u>Chau H. W. L. H. N.</u>				M.D. <u></u>			
PHYSICIAN'S NAME (Type) <u>Chau H. W. L. H. N.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll Road DC</u>				24a. REC'D BY REGISTRAR <u>J. Arthur Walters</u>		24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>	
DATE <u>9/26/57</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 1 1901

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9661

CERTIFICATE OF DEATH

09648

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>19914 MONTAUK AVE</u>	
3. NAME OF DECEASED (Type or print) <u>DOROTHY SPRINGER FAIRFIELD</u>		4. DATE OF DEATH <u>SEPT 16 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 21-1896</u>
9. AGE (In years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROCUREMENT CLERK NAVAL MED. CEN.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAINE</u>	
11. BIRTHPLACE (State or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HARRY E SPRINGER</u>		14. MOTHER'S MAIDEN NAME <u>ABBE ANN HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MR. HAROLD N. FAIRFIELD - HUSBAND</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of Ovaries</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u> <u>6 mo</u> <u>4 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1950</u> to <u>9/16 1957</u> , that I last saw the deceased alive on <u>9/15 1957</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Jagger</u> M.D.		ADDRESS (Street, city or town, state) <u>5707 WISCONSIN AVE</u>	
PHYSICIAN'S NAME (Type) <u>FRANK JAGGERS</u>		DATE SIGNED <u>9/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>9-17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the health certificate be removed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 19 1911
BUREAU V. S.

9662

CERTIFICATE OF DEATH

09649
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salem			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9630 Parkwood Drive				d. STREET ADDRESS Rt. # 2			
3. NAME OF DECEASED (Type or print) First John Middle D. Last FARLEY, Sr.				4. DATE OF DEATH Month September Day 4 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/98		9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Elkhorn, W. Va.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Wm. H. Farley				14. MOTHER'S MAIDEN NAME Florence Ellison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Rachel H. Farley-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricular Stenosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 1-2 Mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-14 , 19 57 , to 9-4 , 19 57 , that I last saw the deceased alive on 9-3- , 19 57 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 221 Fleet Lockett M D 5000 Penn Rd NW Wash DC							
ACTUAL SIGNATURE Wm. Fleet Lockett							
PHYSICIAN'S NAME (Type) Wm. Fleet Lockett							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Bur.-Transit		9/6/57		Ferguson		Roanoke Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 9-4-57		24b. REGISTRAR'S SIGNATURE Bessie M. Simpson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9663

CERTIFICATE OF DEATH

09650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Kensington Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS</u>				d. STREET ADDRESS <u>3000 McComas Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>J.</u> Last <u>AFARRAR</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1886</u>		9. AGE (In years last birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Dept Gov</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Parkinson's disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 19</u> , 19 <u>57</u> , to <u>Sept 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 19</u> , 19 <u>57</u> , and that death occurred at <u>9:10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold F. McCann</u>				ADDRESS (Street, city or town, state) <u>3008-14th N.W.</u>		DATE SIGNED <u>9/24/57</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD F. MCCANN</u>				Wash.		D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>				ADDRESS <u>4812 Hoan Ave</u>		24a. REC'D BY REGISTRAR <u>PC</u> 24b. REGISTRAR'S SIGNATURE <u>SEP 27 1957</u>	

BUREAU V. B.

SEP 27 1957

RECEIVED

9664

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4510 Drummond Avenue				d. STREET ADDRESS 4510 Drummond Avenue			
3. NAME OF DECEASED (Type or print) First MARY Middle ANGELA Last FENWICK				4. DATE OF DEATH Month SEPT. Day 3 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/1874	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months 4 Days 19 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Ignatius J. Fenwick				14. MOTHER'S MAIDEN NAME Julia M. Duncan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Orlene Fenwick— same as Item 2D			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic + other vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic + similar changes DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 10 years 10.70	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic congestive heart failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 19 51 , to Sept 3 19 57 , that I last saw the deceased alive on 9/3 19 57 , and that death occurred at 7:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3100 Conn. Ave. N. W. 9/3/57							
ACTUAL SIGNATURE John V. Dolan M.D.				PHYSICIAN'S NAME (Type) John V. Dolan			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 9-4-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

27 6 1957

RECEIVED

9665

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>4 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>109 NORTH BROOK LANE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES P. FERNALD</u>		4. DATE OF DEATH Month Day Year <u>SEPT 22 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 26 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL TEACHER</u>	
11. BIRTHPLACE (State or foreign country) <u>DISTRICT OF COLUMBIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE W FERNALD</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA GRAHAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>110</u>	
17. INFORMANT <u>SISTER</u> Address <u>BETH. MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Paralysis</u> <u>304X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1957</u> to <u>Sept 22, 1957</u> that I last saw the deceased alive on <u>Sept 19, 1957</u> and that death occurred at <u>12:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. Joyce</u>		ADDRESS (Street, city or town, state) <u>8106 Maple Ridge Rd, Bethesda, Md</u>	
DATE SIGNED <u>9/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumpfrey-Bethesda, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>9-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death Page 4
T FURNISH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 26 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09653

Reg. Dist. No. 514

9666

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2220 Washington Ave. Apt. 202				d. STREET ADDRESS 2220 Washington Ave., Apt. 202			
3. NAME OF DECEASED (Type or print) First Joe Middle Mac Last Foster				4. DATE OF DEATH Month September Day 30 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/20	
9. AGE [In years last birthday] 37 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathmetician - Model Basin, U.S. Gov't.				10b. KIND OF BUSINESS OR INDUSTRY Arkansas City, Kansas		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Joseph V. Foster				14. MOTHER'S MAIDEN NAME Gertrude McMahon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW #2		17. INFORMANT Mr. Joseph V. Foster, 512 South A St. Arkansas City, Kansas			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lacerations of left wrist DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found submerged in bath tub at home							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted deep lacerations of left wrist					
20c. TIME OF INJURY Month, Day, Year Hour ? a.m. 9/30 p.m. 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring, Montgomery, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/1/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 10/2/57		22c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY		22d. LOCATION (City, town, or county) (State) ARKANSAS CITY, KANSAS	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter E. Humphrey</i>				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR ACT 4 1957	
				24b. REGISTRAR'S SIGNATURE <i>Frances Pottery</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED V. S.

NOV 10 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9667

CERTIFICATE OF DEATH

09654

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSITUATION 5077 Bradley Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAE First GIRARD Middle FRAME Last				4. DATE OF DEATH SEPTEMBER 6th. 1957.			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1892	
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louisiana	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Alcee Girard				14. MOTHER'S MAIDEN NAME EMERITE PROVOST			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MRS DUNCAN BROOKS*8503 Irvington St. Bethesda, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MAY , 19 57 , to Sept 6 , 19 57 , that I last saw the deceased alive on Sept 2 , 19 57 , and that death occurred at 3:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1769 Montgomery Lane - Bethesda Md 9-6-57							
ACTUAL SIGNATURE Paul D. Cantor				M.D. 1769 Montgomery Lane - Bethesda Md			
PHYSICIAN'S NAME (Type) Paul D Cantor							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.				ADDRESS		24a. REC'D BY REGISTRAR DATE 9 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

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SEP 9 1957

BUREAU V. S.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809655
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9668

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8704 Sundale Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) William Joseph Gallagher		4. DATE OF DEATH Sept. 6, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1904
9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Stock Market	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Gallagher		14. MOTHER'S MAIDEN NAME Margaret Tracy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 7042-578-46-	
17. INFORMANT Margaret Gallagher (wife)		Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION Trans. Burial		22b. DATE THEREOF 9/9/57	
22c. NAME OF CEMETERY OR CREMATORY Pittston, Pa.		22d. LOCATION (City, town, or county) (State) Pittston, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Timoney		24. REC'D BY REGISTRAR SEP 10 1957	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE Francis Pitter	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SEP 10, 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9669 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09656216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12058 Milton St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Garber</u>				4. DATE OF DEATH Month Day Year <u>Sept 15, 1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown</u>	
9. AGE (In years last birthday) <u>65 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>				13. FATHER'S NAME <u>Mayer Barr</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Morris Goldstein</u> 12058 Milton St., S.S., Md. Same as Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular Accident</u> DUE TO (b) <u>Hypertention</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Diabetes (mild) 5 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes (mild) 5 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9/15/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hillside, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Danzansky & Sons</u> ADDRESS <u>3501-14th St., N.W. Wash.</u> 24c. REC'D BY REGISTRAR <u>SEP 18 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Beanie Thompson</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for and to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 18 1957

NEW YORK

CERTIFICATE OF DEATH

Reg. Dist. No.

216

9670

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived If institut an: Residence before admission) a. STATE Central America b. COUNTY El Salvador c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) San Salvador, Embassy of Guatemala d. STREET ADDRESS San Salvador, Embassy of Guatemala e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Otto Middle Rene Last Garcia		4. DATE OF DEATH Month September Day 16, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1955
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HRS Hours 2 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Central America		12. CITIZEN OF WHAT COUNTRY? Central America	
13. FATHER'S NAME Arturo Garcia		14. MOTHER'S MAIDEN NAME Blanca L. Nisthal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Insufficiency DUE TO Tetology of Fallot (c) Cardiac Surgery			INTERVAL BETWEEN ONSET AND DEATH 5 hours 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Surgery			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 4, 1957 , to September 16, 1957 , that I last saw the deceased alive on September 16, 1957 , and that death occurred at 5:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Waldhausen, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) John A. Waldhausen, M.D.		DATE SIGNED 9/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit	22b. DATE THEREOF 9/17/57	22c. NAME OF CEMETERY OR CREMATORY General Cemetery	22d. LOCATION (City, town, or county) (State) Guatemala City, Guatemala
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 9/18/57	
		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

SEP 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

9671

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1212 Florida Avenue, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Joe Last Gartrell				4. DATE OF DEATH Month September Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 8, 1915	
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME Addison Gartrell				14. MOTHER'S MAIDEN NAME Angeline Simmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Demolition into chest cavity & penetrating shock & cardiac arrest DUE TO Penetrating shock & cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Post-op repair of Atrial Septum for undetected Cardiac DUE TO Post-op repair of Atrial Septum for undetected Cardiac PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington, D.C.	
20f. (City or town) Washington, D.C.				20g. (County) Washington, D.C.		20h. (State) Washington, D.C.	
21. I certify that I attended the deceased from September 8, 1957 , to September 25, 1957 , that I last saw the deceased alive on September 25, 1957 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 9/25/57							
ACTUAL SIGNATURE C. Lombardo				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) C. Lombardo, M.D.				ADDRESS The Clinical Center			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/28/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn	
22d. LOCATION (City, town, or county) Washington, D.C.				22e. (State) Washington, D.C.		22f. (Country) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Allen				ADDRESS 1200 Fla. Ave., N.W. Wn.		24a. REC'D BY REGISTRAR DATE 27 1957	
24b. REGISTRAR'S SIGNATURE Lucille Thompson				24c. REGISTRAR'S SIGNATURE Lucille Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, or by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 27 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9672

Reg. Dist. No.

214

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 yr</u>		d. STREET ADDRESS <u>3301 Janet Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3301 Janet Rd</u>		e. IS DECEASED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>French</u> First <u>Gibson</u> Middle <u>Gibson</u> Last		DATE OF DEATH <u>Sept</u> Month <u>14</u> Day <u>1957</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-17</u> 9. AGE in years (last birthday) <u>40</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bulldozer operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. J.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Shirley Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Bartholow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>World War II</u>		16. SOCIAL SECURITY NO. <u>35-13-3626</u>	
17. INFORMANT <u>Mr Gibson (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u>		<u>sudden</u>	
Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound thru skull</u>			
(c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound thru skull</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:35 p.m. 9-14 1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>9-14-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	22d. LOCATION (City, town, or county) <u>Arlington</u> (State) <u>Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner & Humphrey</u>		24a. REC'D BY REG STRAR <u>SEP 17 1957</u> 24b. REG. STRAR'S SIGNATURE <u>Frances Potter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 17 1957

BUREAU V. S.

9673

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 193 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4415 Iowa Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ada Emma Gordon				4. DATE OF DEATH Month Day Year September 29, 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1896	
9. AGE (In years last birthday) 61 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid (Char Woman)		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James G. Wimberley				14. MOTHER'S MAIDEN NAME Josephine Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-50-3088		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraabdominal lymphoma, type undifferentiated 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20, 1957 to September 29, 1957 that I last saw the deceased alive on September 29, 1957 and that death occurred at 7:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/30/57 ACTUAL SIGNATURE J. C. Allen, M.D. PHYSICIAN'S NAME (Type) J. C. Allen, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire				24a. REC'D BY REGISTRAR OCT 4 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EXHIBIT V. 8

7 4 100

INFORMANT

CERTIFICATE OF DEATH

09661

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hosp.		d. STREET ADDRESS 802 Argyle Rd.	
3. NAME OF DECEASED (Type or print) Mr. Leo Clark Gressley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-01
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Manager		10b. KIND OF BUSINESS OR INDUSTRY Peoples Drug Store #103	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME John Clark Gressley		14. MOTHER'S MAIDEN NAME Josephine Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) NO		16. SOCIAL SECURITY NO 5-78095735	
17. INFORMANT Wife		Address 802 Argyle Rd. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Collagen Disease (Lupus Erythematosus)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH 30 days 40 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1940, to Sept 23 1957, that I last saw the deceased alive on Sept 23 1957, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE W. B. Wardrop		M.D. 837 Bonifant St. Silver Spring Md.	
PHYSICIAN'S NAME (Type) W. B. WARDROP, MD		837 Bonifant St. Silver Spring Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/27/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. S. H. Hines Co 2901 14th St N.W. DC		24a. REC'D BY REGISTRAR SEP 25 1957	
24b. REGISTRAR'S SIGNATURE J. Nelson Dady			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 25 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>8710 Cameron St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mrs. Ida</u> Middle <u>-</u> Last <u>Gudelsky</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>23</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-78</u>	9. AGE (in years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>
13. FATHER'S NAME <u>Jerome Stanley Halper</u>				14. MOTHER'S MAIDEN NAME <u>Gladys -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter Anna Gudelsky</u>		Address <u>8710 Cameron St. S.E. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> 157X DUE TO <u>with Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>to liver and other</u> DUE TO <u>organs.</u> (c) <u>2 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1957</u> Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 20, 1957</u> , to <u>Sept 23, 1957</u> , that I last saw the deceased alive on <u>Sept 23, 1957</u> , and that death occurred at <u>10:47</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H B Orleans</u>				ADDRESS (Street, city or town, state) <u>9500 Colver Rd Silver Spring Md</u>			
DATE SIGNED <u>Sept 26 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-25-57</u>		<u>Arden Park</u>		<u>Barto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Levine</u>				24. REGISTRAR'S SIGNATURE <u>SEP 26 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 26 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

216

9674

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Louisiana</u> b. COUNTY <u>East Baton Rouge</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>33 1/2 hrs</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baton Rouge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1001 Convention St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fred</u> <u>Godlove</u> <u>Hannie</u>		4. DATE OF DEATH Month Day Year <u>9</u> <u>8</u> <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-09</u> 9. AGE (In years last birth day) <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed manager club operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Louisiana</u> 11. BIRTHPLACE (State or foreign country) <u>U. S. A</u>	
13. FATHER'S NAME <u>George T. Hannie</u>		14. MOTHER'S MAIDEN NAME <u>Essie Sourati</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Alice Hannie</u> 17. INFORMANT <u>1001 Convention St. Baton Rouge La.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination due To</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding Esophageal Varices</u> DUE TO (c) <u>Chronic Sclerosis of liver</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 3</u> , 19 <u>57</u> , to <u>Sept. 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 7</u> , 19 <u>57</u> , and that death occurred at <u>4:45 A. M.</u> on the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Joseph A. Bailey</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Joseph A. Bailey</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Bur. - Transit</u>	<u>9/8/57</u>	<u>Rose Lawn</u>	<u>Baton Rouge, La.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9-9-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thornham</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 11 1957

RECEIVED

9675

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>8430 New Hampshire Ave.,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Geraldyn</u> Middle <u>Stich</u> Last <u>HENDRIX</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 February 1915</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Arizona</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Stich</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Husband, Ellis H. HENDRIX</u>		Address <u>(Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute bronchial asthma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11 Sept.</u> , 19 <u>57</u> , to <u>14 Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>14 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>9-14-57</u>			
ACTUAL SIGNATURE <u>W.B. Ingram</u> M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) <u>W. B. INGRAM, CDR, MC USN</u>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>9-14-57</u>	
ADDRESS <u>1551 Wisconsin Ave., Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 17 1957

RECEIVED

9676

CERTIFICATE OF DEATH

Reg. Dist. No.

2.6

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
f. STREET ADDRESS 35 E Street, N. W. Apt. 511				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Elizabeth Last Hilts				4. DATE OF DEATH Month September Day 24 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1903	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 19 Hours 57 Min.		IF UNDER 24 HRS. Months 54 Days 19 Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Kenney				14. MOTHER'S MAIDEN NAME Millie Van Curen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 086-22-1040		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC TUMORS OF LUNG. DUE TO (PRIMARY SITES UNKNOWN) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1-2 YEARS DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYCOSIS FUNGOIDES, CONGESTIVE HEART FAILURE, CACEXIA							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 18, 1957 to September 24, 1957 , that I last saw the deceased alive on September 24, 1957 , and that death occurred at 3:00 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 9/24/57			
ACTUAL SIGNATURE Richard K Shaw M.D.							
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/26/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Pt. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Wash, DC				24a. REC'D BY REGISTRAR 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
CT 1 1957
BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09666

9677

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitorium		d. STREET ADDRESS 6600 Luzon Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last BELLE HOLLANDER		4. DATE OF DEATH Month Day Year 9/22/57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1868
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Zimbarov		14. MOTHER'S MAIDEN NAME Riva Shapiro	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT 6600 Luzon Ave., N.W.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		acute Coronary occlusion Coronary sclerosis Generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947 , 19____, to 9/22/57 , 19____, that I last saw the deceased alive on 9/22/57 , 19____, and that death occurred at 2:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Maurice Protas		ADDRESS (Street, city or town, state) DATE SIGNED 915 - 19th St. N.W. Wash. D.C. 9/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/57	
22c. NAME OF CEMETERY OR CREMATORY Bnai Israel Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons		24a. REC'D BY REGISTRAR DATE 25 1957	
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

RECEIVED
SEP 25 1957
BUREAU V. 31

9678

CERTIFICATE OF DEATH

09667 213
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Zion		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Russell Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle HOLLEY Last HOLLEY		4. DATE OF DEATH Month September Day 7 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Hall		14. MOTHER'S MAIDEN NAME Caroline Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Mary Mumford		Address Germantown, Md. Sister	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerosis DUE TO Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/2/57 to 9/7/57 , that I last saw the deceased alive on 9/5/57 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird		DATE SIGNED 9/10/57	
PHYSICIAN'S NAME (Type) J. W. Bird		M.D. Sandy Sp...	
22a. BURIAL, CREMATION, REPOSAL (Specify) Burial	22b. DATE THEREOF 9/12/57	22c. NAME OF CEMETERY OR CREMATORY Brownstown	22d. LOCATION (City, town, or county) (State) Germantown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24. REG'D BY REGISTRAR (Type) REGISTRAR'S SIGNATURE SEP 16 1957 Sawell Kratoch	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1978

BUREAU V. E.

SEP 16 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

967 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09668 214

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO THE DIRECTOR: Page 3 should be submitted as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12,823 DEAN ROAD				d. STREET ADDRESS 12,823 DEAN ROAD			
3. NAME OF DECEASED (Type or print) GEORGE TALBERT HUTCHINSON				4. DATE OF DEATH SEPTEMBER 21 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEB. 26, 1891	9. AGE (In years, months, days) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY THEATRE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK S. HUTCHINSON				14. MOTHER'S MAIDEN NAME DORA L. WUNDERLICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 577-28-8731A		17. INFORMANT MRS. GLENN E. FEENEY, 12,823 DEAN RD., S.S., MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Found dead in bed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) FRANK J. BROSCHART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED SEPT. 22, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/25/57		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR SEP 24 1957		24b. REGISTRAR'S SIGNATURE Glenn E. Feehey	

RECEIVED

SEP 24 1957

BUREAU V. 31

9680

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut an: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4334 East West Highway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle (No middle name) Last Jacobsen				4. DATE OF DEATH Month September Day 5 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 26, 1945		9. AGE (In years last birthday) 11 yrs	IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles J. Jacobsen				14. MOTHER'S MAIDEN NAME Bess Schwartz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphatic Leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 mo.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 28 , 19 57 , to September 5 , 19 57 , that I last saw the deceased alive on September 5 , 19 57 , and that death occurred at 7:45 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/5/57							
ACTUAL SIGNATURE Dane R. Boggs M.D.				PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burned		22b. DATE THEREOF 4/6/57		22c. NAME OF CEMETERY OR CREMATORY Not known		22d. LOCATION (City, town, or county) (State) near New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE B. Maryland + Sons				ADDRESS 3501 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 9-7-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

SEP 9 1957

RECEIVED

9681

CERTIFICATE OF DEATH

09670

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) o STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
c. LENGTH OF STAY IN 1b <u>19 days</u>		d. STREET ADDRESS <u>Spring Mt</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Huldah</u> First <u>Janney</u> Middle <u>Janney</u> Last		4. DATE OF DEATH <u>Sept 19</u> 19 <u>57</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1877</u> yrs. <u>79</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Newson</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Newby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Marvin (Daughter)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>		<u>1 day</u>	
904.0 DUE TO		<u>6 yrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Chronic Myocarditis</u>	
DUE TO		(c) <u>Fractured left hip</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>fell while alone in garden</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5/5</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Sandy Spring</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>9/18</u> 19 <u>57</u> , to <u>9/19</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/18</u> 19 <u>57</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Sandy Spring MD</u> DATE SIGNED <u>9/19/57</u>	
ACTUAL SIGNATURE <u>C. H. L. 190m</u> M.D.			
PHYSICIAN'S NAME (Type) <u>C. H. L. 190m</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 21, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodside Cemetery</u>	22d. LOCATION (City, town, or county) <u>Nr. Brinklow, Mont.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Laytonville, Md</u>		24a. REC'D BY REGISTRAR <u>9-21-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bertrude B. Lowler</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

RECEIVED

OCT 1 1967

BUREAU V. 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 See Birth Cert. 6-20-57

09671

9682

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park Dorney	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 115 Anderson Court	
3. NAME OF DECEASED (Type or print) First Calvin Middle Earl Last JENNINGS		4. DATE OF DEATH Month September Day 9 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 June 1957
9. AGE (In years last birthday) yrs. 2 Months 19 Days 19 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Donald E. JENNINGS		14. MOTHER'S MAIDEN NAME Camille E. CLEMENT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT (Father) Donald E. JENNINGS (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 7544 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease - truncus, septal DUE TO (c) defect		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 August, 19 57 to 9 Sept., 19 57 , that I last saw the deceased alive on 9 August, 19 57 , and that death occurred at 6:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Daniel Shuptar M.D. U.S. Naval Hospital, Bethesda, Md. 9-9-57.			
ACTUAL SIGNATURE Daniel Shuptar		PHYSICIAN'S NAME (Type) Daniel Shuptar	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE RA Thompson		ADDRESS 2557 Wisconsin Ave., Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 9-9-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 11 1967

BUREAU V. S.

9683

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 4102 Warner St.,	
3. NAME OF DECEASED (Type or print) Elizabeth Stone Johnson		4. DATE OF DEATH Sept. 21 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1917
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR 0 Months 16 Days 18 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Melrose, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred L. Stone	
14. MOTHER'S MAIDEN NAME Dorothy Boyd		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Sullivan V. Johnson, Jr. Address 4102 Warner St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 1.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of Liver DUE TO (c) Malaria & Alcoholism		INTERVAL BETWEEN ONSET AND DEATH 2 day 1 yr Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/13/1957 to 9/21/1957 , that I last saw the deceased alive on 9/21/1957 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones M.D.		ADDRESS (Street, city or town, state) Rockville Md. DATE SIGNED 9/22/57	
PHYSICIAN'S NAME (Type) Stephen N. Jones, M.D.		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/23/1957	22b. DATE THEREOF Cremation	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Prince Georges Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR 9-24-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 26 1967

BUREAU V. S.

9684

CERTIFICATE OF DEATH

09673

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6200 Bradley Blvd.		d. STREET ADDRESS 6200 Bradley Blvd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EDWARD M. JOLLEY First Middle Last		4. DATE OF DEATH Sept. 17, 1957 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1877
9. AGE (In years, day, month, and year) 80		IF UNDER 1 YEAR Months 1 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-18-1720		17. INFORMANT Robert H. Smith-Item # 2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 2 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central Thrombosis DUE TO (c) Central Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 hr. Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epidermal Skin Carcinoma & extreme emaciation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1956 to 9/17, 1957 , that I last saw the deceased alive on 9/12, 1957 , and that death occurred at 10:00 AM , from the causes and on the date stated above.			
SIGNATURE Stephen N. Jones M.D.		ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 9/18/57	
PHYSICIAN'S NAME (Type) Stephen N. Jones			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/19/57	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 9-19-57	24b. REGISTRAR'S SIGNATURE Bessie M. Hargreaves

BUREAU V. 8

SEP 23 1957

RECEIVED

9685

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 10308 Montgomery Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CHARLES C. JONES				4. DATE OF DEATH September 11, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 24, 1899	
9. AGE (in years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 0 Days 17		11. IF UNDER 24 HRS Hours 0 Min. 17			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Eugene Jones				14. MOTHER'S MAIDEN NAME Clara Conley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) None DUE TO (c) None				INTERVAL BETWEEN ONSET AND DEATH Four Hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 9, 1957 to Sept 11, 1957 that I last saw the deceased alive on Sept 10, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Beallsville, Md. DATE SIGNED 10/3/57							
ACTUAL SIGNATURE Samuel Allen M.D.							
PHYSICIAN'S NAME (Type) Samuel Allen-Kensington, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/57		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR OCT 8 1957		24b. REGISTRAR'S SIGNATURE Beattie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

OCT 8 1957

RECEIVED

9686

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia D.C. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Timothy Last Kennedy				4. DATE OF DEATH Month September Day 11 , Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1954	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3		IF UNDER 24 HRS Months 3 Days 3 Hours 3 Min. 3			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James J. Kennedy				14. MOTHER'S MAIDEN NAME Julienne Fenske			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage 40 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Thrombocytopenia DUE TO (c) Acute Lymphatic Leukemia INTERVAL BETWEEN ONSET AND DEATH 5 hours 1 month 6 months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Staphylococcal Septicemia							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour 19 o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 9, 1957 , to September 11, 1957 , that I last saw the deceased alive on September 11, 1957 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dane R. Boggs M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 9-11-57							
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
OCT 9 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9687

CERTIFICATE OF DEATH

09674

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6120 32nd Pl.</u>			
3. NAME OF DECEASED (Type or print) <u>Edwin A Lamke</u>				4. DATE OF DEATH <u>Sept 8 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30 1908</u>	
9. AGE (In years lost birthday) <u>49</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Atomic Energy Comm.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crystal Lake, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes U.S.</u>	
13. FATHER'S NAME <u>George W Lamke</u>				14. MOTHER'S MAIDEN NAME <u>ORAH A Ashley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Wife - Edythe Lamke</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Ruptured Aneurysm, Rt Middle Cerebral Ar</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 8 1957</u> to <u>Sept 8 1957</u> , that I last saw the deceased alive on <u>Sept 8 1957</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Havell</u>				ADDRESS (Street, city or town, state) <u>5516 Nebraska Ave Washington DC</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>				DATE SIGNED <u>9-8-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>9-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

SEP 11 1957

RECEIVED

9688

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY M			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 4 mos. 16 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5604 Montgomery Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Burrows Last LANMAN				4. DATE OF DEATH Month September Day 27 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 April 1909		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Maurice LANMAN				14. MOTHER'S MAIDEN NAME Anna Burrows			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO 212-38-6728		17. INFORMANT Official Navy Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anaplastic Bronchogenic DUE TO Carcinoma with Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Metastasis (Brain, lymph nodes). (b) Metastasis (Brain, lymph nodes). (c) INTERVAL BETWEEN ONSET AND DEATH 9 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 May , 19 57 , to 27 Sept. , 19 57 , that I last saw the deceased alive on 27 Sept. , 19 57 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-28-57							
ACTUAL SIGNATURE Thirl Jarrett M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Thirl Jarrett, CAPT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 Oct. 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey ADDRESS 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 9-28-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
OCT 1957
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

09676

9639

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4812 43rd PLACE NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>WASHINGTON DC</u>	
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>V</u> Last <u>LEITCH</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK OF COMMERCE</u>	9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JULIUS VIEDT</u>		14. MOTHER'S MAIDEN NAME <u>EMMA ZEH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-14-9703</u>	
17. INFORMANT <u>DAUGHTER</u> Address <u>NW 1620 FULLER ST.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>DIABETES MELLITUS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>10 years</u> <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Sept 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 3</u> , 19 <u>57</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Everett</u>		ADDRESS (Street, city or town, state) <u>9400 CONN. AV. KENSINGTON, MD.</u>	
PHYSICIAN'S NAME (Type) <u>John E. Everett</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Ames Co</u> ADDRESS <u>2901 14th St NW Washington, DC</u>		24. REG'D BY REGISTRAR <u>SEP 26 1957</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Essie Thompson</u>		ET	

RECEIVED
SEP 26 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

773

9616

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
3. NAME OF DECEASED (Type or print) First <u>Mathilda</u> Middle <u>Sybelia</u> Last <u>Leonard</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/29/78</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Crossart</u>				14. MOTHER'S MAIDEN NAME <u>Sybelia Bartels</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Daughter</u> Address <u>same as above.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, soft, cerebral</u> DUE TO <u>Thrombosis, left middle cerebral artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9 days</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>T. embolus, left coronary artery & infarct, left ventricle of heart</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-5-</u> 1957, to <u>9-14</u> 1957, that I last saw the deceased alive on <u>9-14</u> 1957, and that death occurred at <u>8:55</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
SIGNATURE <u>Ernest E Harmon</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ERNEST E HARMON</u> <u>9301 Lakeside Rd. Silver Spring</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>CREMATION</u>		<u>9/17/57</u>		<u>FT. LINCOLN CREMATORY</u>		<u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>SEP 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Jolly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 17 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809678
9690
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ellen Mathilde Lyddane</u>		4. DATE OF DEATH Month Day Year <u>Sept 20 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1899</u>
9. AGE (In years last birthday) yrs <u>57</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US. Govt. HEW</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Richard Young</u>		14. MOTHER'S MAIDEN NAME <u>Mollie E. Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Eliot R. Young</u>		Address <u>3252 Aberfoyle Pl. NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left hemiplegia, severe</u> <u>354X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>544+</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 19</u> , 19 <u>57</u> , to <u>Sept 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 19</u> , 19 <u>57</u> , and that death occurred at <u>6:20 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3921 Ingomar St NW Wash D.C. 9.20.57</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Ramsey</u>		24a. REC'D BY REGISTRAR DATE <u>9-21-57</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 11 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9691

CERTIFICATE OF DEATH

09679

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 619 Mississippi Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Melvin Middle Daniel Last Mac Cool				4. DATE OF DEATH Month September Day 15 Year 1957			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Specialist		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Mac Cool				14. MOTHER'S MAIDEN NAME Celeste Hoffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 193-14-9484		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cerebral vascular Disease 331X DUE TO cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from September 14, 1957 to September 15, 1957 , that I last saw the deceased alive on September 15, 1957 , and that death occurred at 6:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/15/57							
ACTUAL SIGNATURE John R. Gill M.D. The Clinical Center				NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) John R. Gill, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR 9-17-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 13 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 18 1957
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09680

Reg. Dist. No. 216

9692

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 7816 Aberdeen Rd.	
3. NAME OF DECEASED (Type or print) Sully Burbank Maize		4. DATE OF DEATH Month Sept. Day 28, Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 6 Days 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographic Eng.		10b. KIND OF BUSINESS OR INDUSTRY U.S.G. Survey	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William R. Maize		14. MOTHER'S MAIDEN NAME Fannie L. Burbank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hosp. Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Dislocation & fracture of C 7 with compression of cord 8 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at home 20c. TIME OF INJURY Month, Day, Year 6 Hour a. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) (County) (State) Bethesda Montg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/2/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 10-1-57	
		24b. REGISTRAR'S SIGNATURE Francis M. Thompson	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

BUREAU V. S.

OCT 2

RECEIVED

9693

CERTIFICATE OF DEATH

09681

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GERMANTOWN</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MARYLANDER REST HOME</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>ELEANOR</i> Middle <i>LOUISE</i> Last <i>MALENFANT</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>4</i> Year <i>1957</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 24, 1881</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>	
11. BIRTHPLACE (State or foreign country) <i>ST. LOUIS, MISSOURI</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HENRY J. BULLMAN</i>		14. MOTHER'S MAIDEN NAME <i>Caroline C. Prasse</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>WW-I</i>	
17. INFORMANT <i>By Deceased - Prior Arrangements.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of rectum - generalized metastases</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 11, 1957</i> , to <i>Sept. 4, 1957</i> , that I last saw the deceased alive on <i>August 30, 1957</i> , and that death occurred at <i>4:40 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James P. Kerr</i>		DATE SIGNED <i>9/4/57</i>	
PHYSICIAN'S NAME (Type) <i>JAMES P. KERR</i>		ADDRESS (Street, city or town, state) <i>Washington, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>9-9-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl. Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Don. DeVol</i>		24a. REC'D BY REGISTRAR <i>2224-Wis An DC</i>	
24b. REGISTRAR'S SIGNATURE <i>Bennie M. Thompson</i>		DATE <i>9-18-57</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 23 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09682

9694

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3903 Jeffry Street</u>				e. STREET ADDRESS <u>3903 Jeffry Street</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> <u>J.</u> <u>Marbaker</u>				4. DATE OF DEATH <u>Sept</u> <u>ber</u> <u>8</u> , 19 <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Marbaker</u>				14. MOTHER'S MAIDEN NAME <u>Almeda Wage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>299-22-1276</u>		17. INFORMANT <u>Vera Marbaker</u> Address <u>3903 Jeffry St. Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of sigmoid with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>23</u> <u>non</u> <u>49</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1957</u> , 19 <u> </u> , to <u>September</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>September 8</u> , 19 <u>57</u> , and that death occurred at <u>9:10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman H. Rubenstein</u> M.D.				ADDRESS (Street, city or town, state) <u>6480 New Hampshire Avenue</u>		DATE SIGNED <u>Sept. 8, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein</u>				Takoma Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Friends</u>		22d. LOCATION (City, town, or county) (State) <u>St. Paul, Sch. L. Tenn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>8434 8th Ave</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 10 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Kelly</u>			

FAU V. S.

SEP 10 1957

RECEIVED

9695

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darby			
f. STREET ADDRESS 15 North 10th Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Leon MARTIN				4. DATE OF DEATH Month Day Year September 27 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 February 1935		9. AGE (In years lost b. rthday) 22 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Soloman C. MARTIN				14. MOTHER'S MAIDEN NAME Florence Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Currently		16. SOCIAL SECURITY NO 162-28-2838		17. INFORMANT (Mother) Mrs. Florence Jackson (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Tumor, type undetermined QUIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH. undetermined	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Sept. , 19 57 , to 27 Sept. , 19 57 , that I last saw the deceased alive on 27 Sept. , 19 57 , and that death occurred at 4:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-28-57							
ACTUAL SIGNATURE John W. Troy M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) John W. TROY, LCDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-57		22c. NAME OF CEMETERY OR CREMATORY Union Hill Cemetery		22d. LOCATION (City, town or county) (State) Kennett Square Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Snowden Funeral Home, 246 N.Wash.Ave., Rockville,				24a. REC'D BY REGISTRAR DATE 9-28-57		24b. REGISTRAR'S SIGNATURE Mary B. Farrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
OCT 1 1957
BUREAU V. S.

9607

CERTIFICATE OF DEATH

09684
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> P.R. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colley Park</u>			
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS <u>4500 Beachwood Rd Takoma Park Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wish. Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby KAREN L. McCrary</u>				4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/17</u>		9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>5</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>Vernon F McCrary</u>				14. MOTHER'S MAIDEN NAME <u>Helen Horney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>V.E. McCrary, (same as #2)</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central vascular accident</u> <u>160.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>prematurity, cerebral vascular defect</u> DUE TO (c) <u>prematurity</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/13/57</u> , 19 <u>57</u> , to <u>9/18/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/18/57</u> , 19 <u>57</u> , and that death occurred at <u>8:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Marvin I. Mones</u> M.D. <u>927</u>				ADDRESS (Street, city or town, state) <u>Pushing Dr. SILVER SPRING, MD</u>		DATE SIGNED <u>9/18/57</u>	
PHYSICIAN'S NAME (Type) <u>MARVIN I. MONES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery Prince Georges Co. Md.</u>		22d. LOCATION (City, town, or county) (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carraway Rd W.D.C.</u>				24a. REC'D BY REGISTRAR <u>J. William R. Doh</u> DATE <u>9/23/57</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SEP 11 1967

BUREAU V. 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9696 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09685

Cerebrovascular accident

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>610 Monroe St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Edith M. Gregor</u> Middle <u>Gregor</u> Last				4. DATE OF DEATH <u>Sept. 7</u> 19 <u>57</u> Month <u>7</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30-1884</u> 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Kirwin-Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Lee Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Amada Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>535-01-7330</u>			
17. INFORMANT <u>Hospital Records and Daughter</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>Yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. <u>—</u> p. m. <u>—</u>				20d. INJURY OCCURRED <u>—</u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>8/9</u> , 19 <u>57</u> , to <u>9/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>57</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Ligon</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. H. LIGON.</u>				DATE SIGNED <u>9/7/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Al Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>	

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09686

9697

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Key Biscayne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 796 Glenridge Road	
3. NAME OF DECEASED (Type or print) First Larry Middle Jerome Last McNally		4. DATE OF DEATH Month September Day 6 Year 19 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1947	9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months 9 Days 19 Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida	
13. FATHER'S NAME Jerome W. McNally		14. MOTHER'S MAIDEN NAME Marjorie Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute aortic insufficiency, operative 42 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ventricular septal defect and pulmonic stenosis DUE TO (c) Congenital					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 3, 1957 , to September 6, 1957 , that I last saw the deceased alive on September 6, 1957 , and that death occurred at 1:20p M , from the causes and on the date stated above.					
ACTUAL SIGNATURE James A. McFarland		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 9/6/57	
PHYSICIAN'S NAME (Type) JAMES A. MC FARLAND, M. D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/9/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Miami Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bowdler Sorenson		1756 ADDRESS Washington, DC		24a. REC'D BY REGISTRAR DATE 9-10-57	24b. REGISTRAR'S SIGNATURE Bessie M Thompson

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SEP 13 1957
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9618

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN TB 38 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10213 Georgia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Henry (M.M.N) Meyer				4. DATE OF DEATH Month Day Year Sept. 7 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-26-87	
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? America							
13. FATHER'S NAME Jacob Martin Meyer				14. MOTHER'S MAIDEN NAME Salomi Sexaur			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO -----		17. INFORMATION Hospital Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Rectal abscess DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Rupture of end to end bowel anastomosis DUE TO Carcinoma of rectum						INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 wks 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from July 30 , 19 57 , to Sept 7 , 19 57 , that I last saw the deceased alive on Sept 6 , 19 57 , and that death occurred at 12:30 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE W.W. Eastman				ADDRESS (Street, city or town, state) 8700 Calverville Rd, Silver Spring Md			
DATE SIGNED 9/9/57							
PHYSICIAN'S NAME (Type) W.W. EASTMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Geo. Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters				ADDRESS 254 Carraway St NW		24a. REC'D BY REGISTRAR J. Wilson	
DATE 9/9/57				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

SEP 10 1957

RECEIVED

9698

CERTIFICATE OF DEATH

Reg. Dist. No.

2-16

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
f. STREET ADDRESS R.F.D. #1, Box 650				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorothy Middle Louise Last Miller				4. DATE OF DEATH Month September Day 3 Year 19 57			
5 SEX Female		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH September 6, 1937	
9. AGE (In years last birthday) yrs 19		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Card Punch Operator		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry F. Miller		14. MOTHER'S MAIDEN NAME Martha I. Robey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Leukemia, acute, lymphocytic DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 days 4 months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 15, 1957 to September 3, 1957 that I last saw the deceased alive on September 3, 1957 and that death occurred at 1:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/3/57 ACTUAL SIGNATURE Martin E. Liebling M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Martin E. Liebling, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9-6-57		St. Johns Cemetery		Clinton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				24a. REC'D BY REGISTRAR SEP 5 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 5 1957

BUREAU V. S.

9619

CERTIFICATE OF DEATH

Reg. Dist. No.

226

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Infant Boy Minchin</u>				4. DATE OF DEATH Month Day Year <u>September 11, 1957</u>			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 10, 1957</u>	
9. AGE (in years last birthday) <u>7</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>7 30</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Kelvin Lennard Minchin</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Joan Lonergan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>prematurity</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-10</u> , 19 <u>57</u> , to <u>9-11</u> , 19 <u>57</u> that I last saw the deceased alive on <u>9-10</u> , 19 <u>57</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ruth Standard</u> M.D.				ADDRESS (Street, city or town, state) <u>Wash. San. Hosp.</u> DATE SIGNED <u>9/17/57</u>			
PHYSICIAN'S NAME (Type) <u>Ruth Standard</u>				<u>Takoma Park Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Hane, M.D.</u> ADDRESS <u>Wash. San. & Hosp.</u>				24a. REC'D BY REGISTRAR <u>9/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. M. Doll</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. V. S.

SEP 18 1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9699

CERTIFICATE OF DEATH

09699

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montg.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE <u>MD</u> c. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodacres MD</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6011 Woodacre Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle <u>C.</u> Last <u>MOORE</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 Aug 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't - Bur. of Ships</u>	
11. BIRTHPLACE (State or foreign country) <u>York County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sidney John Moore</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Watkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Elizabeth A. Moore</u>		Address <u>Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous myocardial infarctions (3)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>57</u> , to <u>Sept</u> 19 <u>57</u> , that I last saw the deceased alive on <u>29 Sept</u> 19 <u>57</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Martyn Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave Bethesda Md</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR M.D</u>		DATE SIGNED <u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	22b. DATE THEREOF <u>10/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Penninsula Mem. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Newport News, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Ernie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 3 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

97-10

CERTIFICATE OF DEATH

09691

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 8329 Draper Lane	
3. NAME OF DECEASED (Type or print) First Pearl Middle Catherine Last Moore		4. DATE OF DEATH Month September Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 4, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Rowlette		14. MOTHER'S MAIDEN NAME Eliza Garner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I attended the deceased from August 14, 1957 , to September 7, 1957 , that I last saw the deceased alive on September 7, 1957 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Lester		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 9/7/57 National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		22b. DATE THEREOF 9/10/57	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Pk. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co.		ADDRESS Wash, D.C.	
24a. REC'D BY REGISTRAR SEP 11 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 11 1957

BUREAU V. 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09692

9701

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5911 Onondago Road				d. STREET ADDRESS 5911 Onondago Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) KATHERINE MORROW				4. DATE OF DEATH Sept. 8, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1878	
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME O. H. Waddle				14. MOTHER'S MAIDEN NAME Hale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT Mrs Edwinna Salladay-Item # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis							
DUE TO 4 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease							
DUE TO Arteriosclerotic Heart Disease							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 1952 to Sept. 1957 , that I last saw the deceased alive on Sept. 2, 1957 , and that death occurred at 7 A. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 16 Georgetown Rd. Bethesda, Md.							
DATE SIGNED 9/9/57							
ACTUAL SIGNATURE Leo I. Donovan M.D.							
PHYSICIAN'S NAME (Type) Leo I. Donovan-8016 Old Georgetown Rd., Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Transit		22b. DATE THEREOF 9/9/57		22c. NAME OF CEMETERY OR CREMATORY Frankfort Cemetery		22d. LOCATION (City, town, or county) (State) Frankfort, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				ADDRESS		24a. REC'D BY REGISTRAR 9-9-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

SEP 11 1977

RECEIVED

9618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
c. LENGTH OF STAY IN 1b 26 yrs.				d. STREET ADDRESS 15 Fayette St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Fayette Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle ALBERT Last MOULDEN				4. DATE OF DEATH Month Sept. Day 12 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1886	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months 10 Days 12 Hours Min. 		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Montgomery Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Olive Moulden				14. MOTHER'S MAIDEN NAME Annie Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-26-6284		17. INFORMANT Wife Frances C. Moulden		Address 15 Fayette St. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) GASTROINTESTINAL Bleeding DUE TO (c) PORTAL CIRRHOSIS						INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 hours 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 26 N. Summit Ave.	
20f. (City or town) Montgomery Co., Md.				20g. (County) Montgomery Co., Md.			
21. I certify that I attended the deceased from Sept. 9, 1957 to Sept. 13, 1957 , that I last saw the deceased alive on 12 Sept. 1957 , and that death occurred at 7 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon S. Rosenberger M.D.				DATE SIGNED 13 Sept 1957			
PHYSICIAN'S NAME (Type) GORDON S. ROSENBERGER				ADDRESS (Street, city or town, state) 26 N. Summit Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey,				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 17 1957	
				24b. REGISTRAR'S SIGNATURE Lawell Hargrove			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 17 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9702

CERTIFICATE OF DEATH

Reg. Dist. No. 096846

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 53 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1511 Van Buren Street, N.W. Is residence on a farm? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Yetta Middle Rosalind Last Neviaser				4. DATE OF DEATH Month September Day 20 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1908	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Merchandise		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel Halpern				14. MOTHER'S MAIDEN NAME Sarah Kallman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of breast & metastases DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 1/2 wks. Sys.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) WASH. D.C.	
20f. (City or town) WASH. D.C.				20g. (County) WASH. D.C.			
20h. (State) WASH. D.C.							
21. I certify that I attended the deceased from July 29, 1957 to September 20, 1957 that I last saw the deceased alive on September 20, 1957 and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Allen D. Doorn M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/22/57		22c. NAME OF CEMETERY OR CREMATORY ELESABETGRAD		22d. LOCATION (City, town or county) (State) WASH. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE D. Baughauser & Sons				ADDRESS 3501-14th St. N.W. WASH. D.C.		24a. REC'D BY REGISTRAR SEP	
24b. REGISTRAR'S SIGNATURE Bessie Thompson							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 25 1957

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9703

CERTIFICATE OF DEATH

09695217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Rhode Island</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Providence</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>67 Mitchell St</u>	
3. NAME OF DECEASED (Type or print) <u>Lula Hazard Olsen</u>		4. DATE OF DEATH <u>Sept. 13 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6 - 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Providence - R.I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William L. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Hazard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> [If yes, give year or dates of service] <u>None</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Hospital Records & Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> DUE TO <u>Myocarditis, Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH, <u>10 min</u> <u>3 yrs</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-18-1957</u> to <u>8-13-1957</u> that I last saw the deceased alive on <u>9-3-1957</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.W. Bird</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>J.W. Bird</u>		DATE SIGNED <u>9/12/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/14/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Cranston, Rhode Island</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 17 1957

BUREAU A. E.



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BUREAU V. S.

SEP 16 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809697

9715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Penna. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) York		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen.				d. STREET ADDRESS 365 Hillcrest Road			
3. NAME OF DECEASED (Type or print) Harry Barton Paschall				4. DATE OF DEATH Month Sept. Day 24 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/27/97	
9. AGE (in years last birthday) 59 yrs		10. IF UNDER 1 YEAR: Months 59 Days 19 Hours 19 Min		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Managing Editor				10b. KIND OF BUSINESS OR INDUSTRY Strength & Health Magazine		17. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Paschall				14. MOTHER'S MAIDEN NAME Cynthia Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 288-03-7536		17. INFORMANT Address Mrs. Tony D. Vittorio, 4285 Lawnview Drive Columbus, Ohio			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) TRANS. & BURIAL				22b. DATE THEREOF 9/28/57		22c. NAME OF CEMETERY OR CREMATORY Ashley Cemetery	
				22d. LOCATION (City, town, or county) (State) Ashley, Ohio			
23. FUNERAL DIRECTOR'S SIGNATURE William E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR SEP 27 1957	
				24b. REGISTRAR'S SIGNATURE Gertrude Lawler			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 27 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

9706

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Georgia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1126 17th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carl Middle Atkinson Last PIERSON, Jr.		4. DATE OF DEATH Month September Day 19 Year 19 57	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Dec. 1929
9. AGE (in years last birthday) 26 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carl Atkinson PIERSON, Sr.		14. MOTHER'S MAIDEN NAME Louise PRATHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Currently		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? Intracerebral Vas. Malformation DUE TO (c) or Aneurysm of Cereb.			INTERVAL BETWEEN ONSET AND DEATH 18 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 18 Sept. , 19 57 , to 19 Sept. , 19 57 , that I last saw the deceased alive on 19 Sept. , 19 57 , and that death occurred at 4:30 A. M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ATTENDING PHYSICIAN'S NAME (Type) Morris H. Lampert		M.D. U.S. Naval Hospital, Bethesda, Maryland	
M.D. Morris H. Lampert, LT, MC, USNR		U.S. Naval Hospital, Bethesda, Md. 9-19-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-23-57	22c. NAME OF CEMETERY OR CREMATORY Riverdale Cemetery	22d. LOCATION (City, town, or county) (State) Columbus, Georgia
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR DATE 9-19-57	
ADDRESS 1557 Wisconsin Ave., Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1937

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9707

CERTIFICATE OF DEATH

09699

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Nursing Home				d. STREET ADDRESS 1021 Rustan St.			
3. NAME OF DECEASED (Type or print) First ESTHER Middle M. Last PLYER				4. DATE OF DEATH Month September Day 4 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min 19		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Garfinckels	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Plyer				14. MOTHER'S MAIDEN NAME Anna L. Moffatt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-0766		17. INFORMANT Mrs. T.B. Marmaduke, 1314 Abington St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATOID ARTHRITIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 12 19 56 to September 4 19 57 , that I last saw the deceased alive on September 4 19 57 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 Norway Dr. DATE SIGNED September 11, 1957							
ACTUAL SIGNATURE Henry M. Lowden M.D.				PHYSICIAN'S NAME (Type) HENRY M. LOWDEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 9/10/57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

BUREAU V. S.

SEP 13 1957

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9708

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 35 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 183			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Janet Middle Frances Last Powell				4. DATE OF DEATH Month September Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 21, 1943	
9. AGE (in years last birthday) 13 yrs.		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min 13		IF UNDER 24 HRS Months 13 Days 13 Hours 13 Min 13			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Arthur T. Powell				14. MOTHER'S MAIDEN NAME Pauline M. Cornell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 7544 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Mitral & Tricuspid Stenosis (c) Acute Septal Myocardial Infarction (Pinfarct) & Septal Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 12 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 11, 1957 to September 15, 1957 that I last saw the deceased alive on September 15, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Carlos R. Lombardo M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Carlos R. Lombardo, M. D.				DATE SIGNED 9/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial - Sept. 18, 1957				Sept. 18, 1957		Chestnut Grove Cemetery, Herndon, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Berkeley Green - Herndon, Va.				ADDRESS Herndon, Va.		24a. RECEIVED BY REGISTRAR DATE 9-16-57	
						24b. REGISTRAR'S SIGNATURE Bessie M. Kumpson	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 19 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9799

CERTIFICATE OF DEATH

09701

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 517 West "B" Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Jane Last Powers		4. DATE OF DEATH Month September Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1890
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles McLaughlin		14. MOTHER'S MAIDEN NAME Malinda Sutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Curculiosis - Type ? DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1957 , to September 15, 1957 , that I last saw the deceased alive on September 15, 1957 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Leon G. Smith M.D.		The Clinical Center	
PHYSICIAN'S NAME (Type) LEON G. Smith		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF SEP 18 1957	22c. NAME OF CEMETERY OR CREMATORY Verona Va.	22d. LOCATION (City, town, or county) (State) Verona Va.
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Halli Bros.		24. REGISTRAR'S SIGNATURE Bessie Thompson	
ADDRESS Brunswick		DATE SEP 12 1957	

RECEIVED

SEP 20 1957

BUREAU V. S.

WLS
Kane

9710

CERTIFICATE OF DEATH

09702

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in 1b 16 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3212 Newark St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marion Howe PRICE		4. DATE OF DEATH Month Day Year September 14 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Jan. 1871
9. AGE (In years last birthday) yrs 86		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jearad HOWE		14. MOTHER'S MAIDEN NAME Eleanor E. HARWOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, left middle cerebral artery 3 wks. 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, cerebral DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 wks. yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 29 Aug. , 19 57 , to 14 Sept. , 19 57 , that I last saw the deceased alive on 13 Sept. , 19 57 , and that death occurred at 1:40 A. M, from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-14-57 ACTUAL SIGNATURE W B Ingram M.D. PHYSICIAN'S NAME (Type) W. B. INGRAM, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremeration	22b. DATE THEREOF 9-16-57	22c. NAME OF CEMETERY OR CREMATOR Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W. B. Ingram GAYLER & Sons, 1756 Penn. Ave., N.W. Wash.D.C.		24a. REC'D BY REGISTRAR 9-14-57 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 17 1957
BUREAU V. S.

9711

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 118 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3033 16th Street, N. W.			
3. NAME OF DECEASED (Type or print) First Middle Last Roy Warren Price, Jr.				4. DATE OF DEATH Month Day Year September 30 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1925	9. AGE (In years last birthday) 31 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		10b. KIND OF BUSINESS OR INDUSTRY Social Service		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy W. Price, Sr.				14. MOTHER'S MAIDEN NAME Eva Palazzie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 047-14-4144		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> 4400 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CONGESTIVE HEART FAILURE, AZOTEMIA</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>							INTERVAL BETWEEN ONSET AND DEATH 4 YEARS 6 YEARS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 19 57, to September 30, 19 57, that I last saw the deceased alive on September 30, 19 57, and that death occurred at 6:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/1/57							
ACTUAL SIGNATURE Louis Gillespie, Jr. PHYSICIAN'S NAME (Type) Louis Gillespie, Jr., M. D.				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-2-57		22c. NAME OF CEMETERY OR CREMATORY Lees' Crematorium		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS Washington D.C.		24. REG'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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SEP 24 1957

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 could be detached for use on the burial-transit permit. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9611

CERTIFICATE OF DEATH

09705 1/17

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tahoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tahoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>7110 Sycamore Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>R</u> Last <u>PULLIAM</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-11</u>
9. AGE (in years last birthday) <u>46</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. TERMINAL</u>	
11. BIRTHPLACE (State or foreign country) <u>Remington Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Pulliam</u>		14. MOTHER'S MAIDEN NAME <u>Cassie Mae Spicer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret E Pulliam</u>		Address <u>7110 Sycamore Ave Tahoma Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, ACUTE</u> DUE TO (b) <u>RIGHT HEART FAILURE AND CORONARY INSUFFICIENCY</u> DUE TO (c) <u>8/23/57</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-5-</u> 19 <u>57</u> , to <u>9-20</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9-16-</u> 19 <u>57</u> , and that death occurred at <u>10:15</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>S. A. Hillman</u> M.D. <u>Samuel A. Hillman, M.D.</u> <u>249 Missouri Ave., N.W.</u> <u>Washington 11, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM</u>		22d. LOCATION (City, town, or county) (State) <u>KYATTSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>		24. REC'D BY REGISTRAR <u>SEP 23 1957</u>	
ADDRESS <u>4812 Hia Ave</u>		REGISTRAR'S SIGNATURE <u>J. Hillman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09706

9712

CERTIFICATE OF DEATH

Reg. Dist. No.

211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Cedar Grove				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 1, Gaithersburg				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Lavinia Purdum				4. DATE OF DEATH Month Day Year Sept. 7 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1872	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
13. FATHER'S NAME Richard Murdock				14. MOTHER'S MAIDEN NAME Mary Medairy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address LeRoy Purdum, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Patent arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10, 1948 to Sept. 7, 1957 , that I last saw the deceased alive on August 30, 1957 , and that death occurred at 12 noon from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 9/8/57 ACTUAL SIGNATURE John P. Kern M.D. PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Upper Seneca		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Moleworth ADDRESS Damascus, Md.				24a. REC'D BY REGISTRAR DATE Sept 9/57		24b. REG. STRAR'S SIGNATURE Della W. Burdette	

RECEIVED

SEP 17 1957

BUREAU V. S.

09707

MARYLAND STATE DEPARTMENT OF HEALTH

9713

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Washington, D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Kensington		LENGTH OF STAY (in this place) 21 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kensington Gardens Sanitarium 3000 Mc Conas Avenue		STREET ADDRESS 2434 - 59th St NW			
3. NAME OF DECEASED (Type or Print) Case	(First) B	(Middle) Rafter	(Last)	4. DATE OF DEATH 9-15-57	(Month) (Day) (Year)
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan 21, 1890	9. AGE last birthday 67 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Scott Rafter		14. MOTHER'S MAIDEN NAME Mary Elizabeth Connell		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS Wife Mrs. Case B Rafter	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Terminal pneumonia**INTERVAL BETWEEN
ONSET AND DEATH**18 hours**

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last(b) **Parkinson's disease****10 years**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE**None**PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
m. Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **fall** 19**34**, to **Sept. 18th** 19**57**, that I last saw the deceasedalive on **9/18/57**, 19**57**, and that death occurred at **1:10 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)**Burial**

DATE THEREOF

9/20/57

NAME OF CEMETERY OR CREMATORY

Arlington National

LOCATION (City, town, or county)

Arlington, Virginia

(State)

DATE REC'D BY LOCAL
REG.**9-26-57**

REGISTRAR'S SIGNATURE

Frances Patten

FUNERAL DIRECTOR

Joseph J. Williams, 1750 14th Ave. NW

ADDRESS

Wash DC

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. H.

1957 C. C.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9714

CERTIFICATE OF DEATH

09708

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b <u>20 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanatorium</u>				d. STREET ADDRESS <u>3601 Chesapeake St., N. W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>MARGARET REED</u> Middle <u>REED</u> Last		4. DATE OF DEATH <u>SEPT 15 1957</u> Month <u>15</u> Day <u>15</u> Year <u>1957</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 6, 1865</u>	9. AGE (In years last birthday) <u>92</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13. FATHER'S NAME <u>August Koenecke</u>				14. MOTHER'S MAIDEN NAME <u>Fredericka ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Robert V. Russell</u> Address <u>EM 3-2121</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>352X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IMPACTED FRACTURE, LEFT HIP</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 30, 1957</u> to <u>Sept 15, 1957</u> that I last saw the deceased alive on <u>SEPT 15 1957</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert T. Thibodeau</u>				ADDRESS (Street, city or town, state) <u>10609 CONCORD ST</u>		DATE SIGNED <u>9-15-57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBODEAU, KENSINGTON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 9-18-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9-17-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

RECEIVED

SEP 18 1957

BUREAU V. S.

09710

9612

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.			
c. LENGTH OF STAY IN 1b 38 Days				d. STREET ADDRESS 1805 Good Hope Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) David John Rees				4. DATE OF DEATH September 30 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-92	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Classified--National Security Agency		11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME William G. Rees				14. MOTHER'S MAIDEN NAME Sarah Wells			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO -----		17. INFORMANT Hospital Records Address -----			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Pyelonephritis							
181X DUE TO (b) Carcinoma of bladder							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Multiple abscesses of lung Acute Parotitis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple abscesses of lung Acute Parotitis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-23-57 , 19 57 , to 9-30-57 , 19 57 , that I last saw the deceased alive on 9-29-57 , 19 57 , and that death occurred at 2:45 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur E. Coyne				ADDRESS (Street, city or town, state) Takoma Park Md DATE SIGNED 9-30-57			
PHYSICIAN'S NAME (Type) ARTHUR E. COYNE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2-1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Rees ADDRESS 1805 Good Hope Rd.				24. REC'D BY REGISTRAR 1		24b. REGISTRAR'S SIGNATURE William Rees	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOT 2 1907

INVESTIGATION

9715

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3064 30th St. SE.</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>M</u> Last <u>Reeds</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Office Bldg Hinesberg, Illinois</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Franklin Reeds</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-28-6309</u> <u>Unknown</u>	
17. INFORMANT <u>Irene Reeds Danowsky</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fatal Cardiac Arrhythmia</u> <u>no</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic</u> DUE TO (c) <u>Heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>52</u> to <u>Sept 7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 7</u> 19 <u>57</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Michael M Healy</u> M.D.			
PHYSICIAN'S NAME (Type) <u>MICHAEL M HEALY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>Washington D.C.</u>	24a. REC'D BY REGISTRAR <u>Beenie M Thompson</u>
		DATE <u>9-11-57</u>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

SEP 16 1957

RECEIVED

9716

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL) Silver Spring				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 833 Gist Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lemuel Hickie Rinker				4. DATE OF DEATH Month Day Year Sept. 23 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/82	9. AGE (In years last birthday) yrs. 75	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Operator				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mt. Jackson, Va.	
13. FATHER'S NAME Lemuel H. Rinker				14. MOTHER'S MAIDEN NAME Mary Ellen Zirkle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-03-0639			
				17. INFORMANT Cora L. Rinker Address 833 Gist Ave. S.S. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 4, 1957 to Sept. 23, 1957 , that I last saw the deceased alive on Sept. 22, 1957 , and that death occurred at 6:50 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 9241 Cal. Blvd Silver Spring, Md. DATE SIGNED 9/23/57							
ACTUAL SIGNATURE Marion Bausch							
PHYSICIAN'S NAME (Type) Silver Spring, Md.							
22a. BURIAL, CREMATION, or other disposition (Specify) burial				22b. DATE THEREOF 9/26/57		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
				22d. LOCATION (City, town, or county)		(State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR SEP 25 1957	
				24b. REGISTRAR'S SIGNATURE Francis Patton			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 25 1957

BUREAU V. S.

9717

CERTIFICATE OF DEATH

09712

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 32 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d STREET ADDRESS 5406 Seminary Road			
3 NAME OF DECEASED (Type or print) First James Middle Alfred Last Roberts				4. DATE OF DEATH Month September Day 27 , Year 1957			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 20, 1915	9. AGE (In years last birthday) 41 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Installer		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel D. Roberts				14. MOTHER'S MAIDEN NAME Myrtle Weakley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-07-7167		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hodgkins Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from August 26, 1957 , to September 27, 1957 , that I last saw the deceased alive on September 27, 1957 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Roger Lester		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Roger Lester		DATE SIGNED 9/27/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-1-57	22c. NAME OF CEMETERY OR CREMATORY Wash. Nat.		22d. LOCATION (City, town, or county) (State) Switzland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Wash. D.C.		ADDRESS		24a. REC'D BY REGISTRAR OCT 2 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU U. S.

OCT 2 1957

RECEIVED

09713

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9718

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>Rt 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA Isabelle Robinson</u>				4. DATE OF DEATH Month Day Year <u>Sept 7 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 15, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs		FUNDER 1 YEAR IF UNDER 24 HRS		Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poolesville, Md.</u>	
13. FATHER'S NAME <u>Frank Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Prumer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Husband, Charles Robinson, Md. Rt 1 Poolesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Embolism</u> DUE TO (c) <u>Auricular fibrillation with mural thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 18, 1957</u> to <u>Sept 7, 1957</u> , that I last saw the deceased alive on <u>Sept 6, 1957</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>26 N. Summitt Ave.</u> DATE SIGNED <u>9A HARRIS BURG, MD.</u>							
ACTUAL SIGNATURE <u>Gordon Rosenberg</u>				PHYSICIAN'S NAME (Type) <u>9A HARRIS BURG, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Poolesville,</u>		22d. LOCATION (City, town or county) (State) <u>Poolesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Saunden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 16 1957

BUREAU V. 3

9719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
 execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>1 yr</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12413 Denley Rd</u>			d. STREET ADDRESS <u>12413 Denley Rd</u>		
3. NAME OF DECEASED (Type or print) <u>Nicholas Raymond Roseway Sr</u>			4. DATE OF DEATH <u>Sept 12 1957</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 23-1886</u>		9. AGE (in years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR? IF UNDER 24 HRS? Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>stone keeper</u>		
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		
13. FATHER'S NAME <u>Charles Roseway</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth May</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>N.R. Roseway Jr</u>		
17. INFORMANT <u>Stem #2</u>			Address <u>Stem #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>					
420.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Booschant</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. BOOSCHANT</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>9-12-57</u>		
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town or county) <u>Colmar Manor, Md.</u>		22e. (State)		22f. (City, town or county)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Md.</u>			ADDRESS		
RECEIVED BY REGISTRAR <u>SEP 13 1957</u>			24b. REGISTRAR'S SIGNATURE <u>James Patten</u>		

RECEIVED

SEP 13 1957

BUREAU V. S.

09715

9613

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington D. C.	
c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 1259 New Hampshire Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Jenny Laurence Sagen		4. DATE OF DEATH Month Day Year Sept. 28 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-87
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? Norway ✓	
13. FATHER'S NAME Osten Sagen		14. MOTHER'S MAIDEN NAME Louise Siursen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 3X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrectomy, left DUE TO (c) Intra-renal hemorrhage.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent hysterectomy for carcinoma of endometrium			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 18 Sept. 1957 to 28 Sept. 1957 , that I last saw the deceased alive on 27 Sept. 1957 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE A. J. Wilets M.D.			
PHYSICIAN'S NAME (Type) A. J. Wilets			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10/3/1957	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Hines Co., Washington 9, D.C.		24a. REC'D BY REGISTRAR J. Wilson Dodd	24b. REGISTRAR'S SIGNATURE J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 2

RECEIVED

9614

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7700 Blair Rd		d. STREET ADDRESS 7700 BLAIR RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JENNIE Middle SAKOFSKY Last SAKOFSKY		4. DATE OF DEATH Month 9 - Day 7 - Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 5, 1889
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) HONESDALE PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME ELIAS ABRAMS		14. MOTHER'S MAIDEN NAME BERTHA ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 190-14-1356	
17. INFORMANT HARRY SAKS-10442 Adthing-St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF GALL BLADDER DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-23- , 19 55 , to 9-7 , 19 57 , that I last saw the deceased alive on 9-6-57 , 19 57 , and that death occurred at 5:03 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome J. Kruck		ADDRESS (Street, city or town, state) 2800 Quebec St N.W.	
PHYSICIAN'S NAME (Type) JEROME J. KRICK		DATE SIGNED 9-7-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 9, 1957	22c. NAME OF CEMETERY OR CREMATORY TEMPLE ISRAEL CEMETERY	22d. LOCATION (City, town, or county) (State) DUNMORE PA
23. FUNERAL DIRECTOR'S SIGNATURE B. D. ...		24. REG'D BY REGISTRAR ...	
ADDRESS 3501-14 St NW		DATE 10/5/57	
24b. REGISTRAR'S SIGNATURE ...			

MEDICAL CERTIFICATION

RECEIVED

SEP 13 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9720

CERTIFICATE OF DEATH

09717

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 103 days		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3807 Benton Street, N. W.	
3. NAME OF DECEASED (Type or print) First Janet Middle Eileen Last Sams		4. DATE OF DEATH Month September Day 9 Year 19 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1918	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 39 Days 9 Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Connecticut	
13. FATHER'S NAME Eugene Mitchell		14. MOTHER'S MAIDEN NAME Mae Mannion			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-28-4884		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 10 - v DUE TO Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Disease in Lung & Pleural Effusion (c) Malignant Melanoma					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from May 29, 1957 to September 9, 1957 that I last saw the deceased alive on September 9, 1957 and that death occurred at 7:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
ACTUAL SIGNATURE Arthur J. Garceau, M.D.		DATE SIGNED 9/9/57			
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-11-57	22c. NAME OF CEMETERY OR CREMATORY National Memorial Park	22d. LOCATION (City, town, or county) (State) Falls Church Va		
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home		ADDRESS 4812 Ga Ave NW		24. REC'D BY REGISTRAR SEP 11 1957	
				25. REGISTRAR'S SIGNATURE Bessie Thompson	

RECEIVED

P 11 1957

TAU V. 6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09718213

9619

OR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a STATE <u>md</u> b COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>907 Grandin Ave</u>		d STREET ADDRESS <u>1910 Vienna Mill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Frank Conrad Schneider Sr.</u>	4. DATE OF DEATH <u>Sept 5 1957</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1886</u>
9. AGE (in years, last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		12. KIND OF BUSINESS OR INDUSTRY <u>OWN business</u>	
13. BIRTHPLACE (State or foreign country) <u>Va</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. FATHER'S NAME <u>John Schneider</u>		16. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		18. SOCIAL SECURITY NO <u>578-03-4628A</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		20. INTER ALIUD CAUSE OF DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>		<u>sudden</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>Coronary occlusion</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
22a. TIME OF INJURY Month, Day, Year Hour <u>19</u> m <u>19</u> p <u>19</u>		22b. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>9/5/57</u>			
24a. BURIAL, CREMATORY, REMOVAL (Specify) <u>Burial</u>		24b. DATE THEREOF <u>9/9/57</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25b. ADDRESS <u>Bethesda, Maryland</u>	
25c. DATE <u>SEP 9 1957</u>		25d. REGISTRAR'S SIGNATURE <u>Lawell Keston</u>	

RECEIVED

SEP 9 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9721

CERTIFICATE OF DEATH

09719

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Kansas b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 157 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Osborne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 222 North First Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gaybert Middle Phil Last Schroeder		4. DATE OF DEATH Month September Day 21 Year 57					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1926	9. AGE (In years last birthday) 30 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Buyer		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ernest P. Schroeder				14. MOTHER'S MAIDEN NAME Edyth Skewes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW II 507-36-9526		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Intestate carcinoma DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 7 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 1957 to September 21, 1957 , that I last saw the deceased alive on September 21, 1957 , and that death occurred at 2:55p M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 9/22/57			
ACTUAL SIGNATURE Allen D. Goodman M.D.		M.D. Allen D. Goodman, M. D.		National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Translt		22b. DATE THEREOF 9/22/57		22c. NAME OF CEMETERY OR CREMATORY Imperial		22d. LOCATION (City, town or county) (State) Chase County, Nebraska	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 9-24-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 28 1957
BUREAU V. S.

9722

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 73 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 8737 Carroll Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alfred Middle James Last Serbin		4. DATE OF DEATH Month September Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 26, 1904
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Engineer		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Serbin		14. MOTHER'S MAIDEN NAME Fanny Bloom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 111077096	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA RIGHT LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 7 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute duodenal ulcer			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1957 , to September 23, 1957 , that I last saw the deceased alive on September 23, 1957 , and that death occurred at 2:15 P. M. from the causes and on the date stated above. ADDRESS [Street, city or town, state] DATE SIGNED The Clinical Center 9/23/57 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Edward W. Moore M.D.			
PHYSICIAN'S NAME (Type) EDWARD W. MOORE, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Va
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		ADDRESS 3501 14th St., N.W.	
24a. REC'D BY REGISTRAR SEP 27 1957		24b. REGISTRAR'S SIGNATURE James Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 27 1957

RECEIVED

9723

CERTIFICATE OF DEATH

09721

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN TB <u>25 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>1820 Fort Davis Street, S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sylvia</u> Middle <u>Belle</u> Last <u>SESSIONS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Sept. 1912</u>
9. AGE (In years last birthday) <u>45</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William BOYD</u>		14. MOTHER'S MAIDEN NAME <u>Florence Haley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Sister) Mrs. Leola L. BOYD (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Glioblastoma multiforme</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o m <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 August</u> , 19 <u>57</u> to <u>14 Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>6:40A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>9-14-57</u>			
ACTUAL SIGNATURE <u>John W. Troy</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John W. Troy, LCDR, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-17-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mattingly</u>		24. REC'D BY REGISTRAR <u>9-14-57</u>	
ADDRESS <u>Mattingly, 131 11th St. S.E. Washington, D.C.</u>		25. REGISTRAR'S SIGNATURE <u>May E. Farrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 17 1937

RECEIVED

CERTIFICATE OF DEATH

09722

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 46 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1692 Whitney Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Arthur Last SHARP				4. DATE OF DEATH Month September Day 3 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 March 1906	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy			
11. BIRTHPLACE (State or foreign country) Connecticut				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Arthur SHARP				14. MOTHER'S MAIDEN NAME Lorraine PARR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I and II				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Mrs. Fredericka SHARP, (Wife) (Same as #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Tumor (Glioma) 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 15 June , 19 57 , to 3 Sept. , 19 57 , that I last saw the deceased alive on 31 Aug. , 19 57 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-3-57							
ACTUAL SIGNATURE W. H. Druckemiller M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) W. H. DRUCKEMILLER, CAPT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-57		22c. NAME OF CEMETERY OR CREMATORY Arlington, Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Plamphrey ADDRESS 4557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 9-3-57			
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

EP 5 1957

BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9725

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 62 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. STREET ADDRESS 3910 Ingomar Street, N. W.				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wanda Middle Frances Last Shea				4. DATE OF DEATH Month September Day 18 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1914 September 9, 1914	
9. AGE (In years last birthday) 43		10. IF UNDER 1 YEAR Months 28 Days 18 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Writer				10b. KIND OF BUSINESS OR INDUSTRY Publishing			
13. FATHER'S NAME Milton Hair				14. MOTHER'S MAIDEN NAME Eula Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 14X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myeloid Metaplasia DUE TO (c) Polycythemia Vera INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years 12 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 18, 1957 , to September 18, 1957 , that I last saw the deceased alive on September 18, 1957 , and that death occurred at 4:20 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles G. Lewallen M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/18/57			
PHYSICIAN'S NAME (Type) CHARLES G. LEWALLEN, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawler's Sons, Wash., D. C.				24a. REC'D BY REGISTRAR DATE 9-21-57			
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

BUREAU V. S.

SEP 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09724
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 9726 Reg. Dist. No. 214

FOR STATE
 HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
 execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 12 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3930 Washington St.		e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Kensington	
3. NAME OF DECEASED (Type or print) Margaret Simpson Sheppard		4. DATE OF DEATH Month Sept Day 1 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 7/30/1904	9. AGE (in years last birthday) 53 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Mexico
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wm. P. Simpson	
14. MOTHER'S MAIDEN NAME Lillie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Sherman Sheppard (husband) Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of left breast with metastasis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 9/2/57	
EXAMINER'S NAME (Type) Frank J. Broschart		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION CREMATION	22b. DATE THEREOF 9/2/57	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	22d. LOCATION (City, town, or county) (State) Prince George County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.	24a. REC'D BY REGISTRAR 9/5/57
		24b. REGISTRAR'S SIGNATURE Francis J. Miller	

RECEIVED

SEP 9 1957

BUREAU V. S.

9727

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4121 Woodbine Street</u>	
3. NAME OF DECEASED (Type or print) <u>ERNEST R. SLADE</u>		4. DATE OF DEATH <u>Sept 18 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/96</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>Gloversville, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Albert Parsons Slade</u>		14. MOTHER'S MAIDEN NAME <u>Alice Harrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Alice Slade</u>		Address <u>4121 Woodbine St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>10 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1957</u> to <u>Sept 18 1957</u> , that I last saw the deceased alive on <u>Sept 18 1957</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W. Wash D.C.</u> DATE SIGNED <u>9-18-57</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St. N.W. Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Transf</u>		22b. DATE THEREOF <u>9/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ferndale</u>		22d. LOCATION (City, town, or county) (State) <u>Gloversville, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>9-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beaice M. Compton</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 27 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>225 Dill Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Bernard</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept. -1, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Navy Yard</u>	
11c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christopher P. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Helen Regina Ely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-26-8251</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PURULENT PERITONITIS, Generalized</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF STOMACH</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hr.</u> <u>6 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 12</u> , 19 <u>57</u> , to <u>September 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>September 14</u> , 19 <u>57</u> , and that death occurred at <u>2:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>9/15/57</u> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE <u>James L. Cerman, M.D.</u>		PHYSICIAN'S NAME (Type) <u>James L. Cerman, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-17-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick- Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Cline & Son</u> W, ADDRESS <u>Frederick-Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>Sept 17, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

SEP 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9728

CERTIFICATE OF DEATH

09727

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS St. John's Manor			
3. NAME OF DECEASED (Type or print) First Georgia Middle Christine Last Snader				4. DATE OF DEATH Month September Day 17 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 13, 1951	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 5 Days 17 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earle S. Snader				14. MOTHER'S MAIDEN NAME Patricia Beall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage DUE TO Acute lymphoblastic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 1/2 yrs DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour 19 Month, 19 Day, 19 Year a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ellicott City, Maryland	
20f. (City or town) Ellicott City, Maryland				20g. (County) Howard			
20h. (State) Maryland				20i. (City or town) Ellicott City, Maryland			
21. I certify that I attended the deceased from September 6, 1957 , to September 17, 1957 , that I last saw the deceased alive on September 17, 1957 , and that death occurred at 8:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Roger Lester				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Roger Lester, M. D.				DATE SIGNED 9/17/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Johns	
22d. LOCATION (City, town, or county) Ellicott City, Maryland				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons				ADDRESS 1900 Eutaw Place			
DATE SEP 17 1957				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

RECEIVED
SEP 24 1957
BUREAU V. S.

9615

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium		d. STREET ADDRESS 5726 1st Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PAM DEN GRAS First Middle Last		4. DATE OF DEATH September 7 Month Day Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH - -
9. AGE (In years last birthday) 43 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chancellor Embassy of Republic of Indonesia		10b. KIND OF BUSINESS OR INDUSTRY Indonesia	
11. BIRTHPLACE (State or foreign country) Indonesia		12. CITIZEN OF WHAT COUNTRY? Indonesia	
13. FATHER'S NAME unobtainable		14. MOTHER'S MAIDEN NAME unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO	
17. INFORMANT Embassy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Post-operative shock 602X DUE TO RT Nephrolithotomy (Stag horn calculus) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Stag horn calculus (kidney) and suppurative pyelitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Stag horn calculus (kidney) and suppurative pyelitis			
INTERVAL BETWEEN ONSET AND DEATH 36 hrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/26 , 1957, to 9/5 , 1957 that I last saw the deceased alive on 11/5 , 1957, and that death occurred at 6:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 909 Pennsylvania Ave., N.W., Washington, D.C. DATE SIGNED Arthur J. Wilets			
ACTUAL SIGNATURE Arthur J. Wilets		PHYSICIAN'S NAME (Type) Arthur J. Wilets	
22a. BURIAL - CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9/10/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., S.E.		24a. REC'D BY REGISTRAR SEP 10 1957	24b. REGISTRAR'S SIGNATURE J. Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9729 CERTIFICATE OF DEATH

Reg. Dist. No. 09329

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 66 Hurd Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frederick Middle August Last Sohn				4. DATE OF DEATH Month September Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 30, 1911	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Assembly			10b. KIND OF BUSINESS OR INDUSTRY Machinery		11. BIRTHPLACE (State or foreign country) New Jersey		
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Christian G. Sohn				14. MOTHER'S MAIDEN NAME Julia Koch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give year or dates of service)) No		16. SOCIAL SECURITY NO. 144-07-8093		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra cranial (intraventricular) hemorrhage 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Malignant Melanoma, metastatic to brain & lungs DUE TO (c) Malignant Melanoma, skin, right mandibular region INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos 2 1/2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 16, 57 to September 23, 57 that I last saw the deceased alive on September 23, 1957 and that death occurred at 3:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Moore M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 9/23/57	
PHYSICIAN'S NAME (Type) EDWARD W. MOORE, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/57		22c. NAME OF CEMETERY OR CREMATORY Locust Hill		22d. LOCATION (City, town, or county) (State) Dover, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 9-26-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09730 216
Reg. Dist. No.

9730

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3805 Raymond Street				d. STREET ADDRESS 3805 Raymond Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Gardner Last Squires				4. DATE OF DEATH Month September Day 27 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/4/91	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66		IF UNDER 24 HRS. Hours 66 Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner-Federal Dept. Ins. Corp.				10b. KIND OF BUSINESS OR INDUSTRY Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Cyrus Squires				14. MOTHER'S MAIDEN NAME Katherine Gardner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Navy WW # 1		17. INFORMANT Edward C. Squires Address 3805 Raymond St. CC. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 5 weeks - DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 weeks -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John G. Ball				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/1/57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,				ADDRESS Wash, D.C.		24. REC'D BY REGISTRAR SEP 30 1957	
				24b. REGISTRAR'S SIGNATURE Lessie Thompson			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. I.

SEP 1951

RECEIVED

9731

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1415 Highland Drive				d. STREET ADDRESS 1415-Highland Drive			
3. NAME OF DECEASED (Type or print) First Claire Middle Johnson Last Stevens				4. DATE OF DEATH Month Sept Day 19 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SINGLE	8. DATE OF BIRTH 10/25/1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hiram Johnson			14. MOTHER'S MAIDEN NAME Frances M. Gale				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT James M. Stevens		Address Silver Spring, Md. -1415 Highland Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 572.1 DUE TO acute gastroenteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) perforated ulcer of (antrum) (c) generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 4 days 5-10 15 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1957 to 9/19 , 19 57 that I last saw the deceased alive on 9/19 , 19 57 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Burns				ADDRESS (Street, city or town, state) 915-19th St. N.W. Wash D.C.			
PHYSICIAN'S NAME (Type) JAMES T. BURNS, M.D.				DATE SIGNED 9/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 9/21/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. Wash DC				24a. REC'D BY REGISTRAR SEP 24 1957		24b. REGISTRAR'S SIGNATURE Frances Patten	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 04 1 7

RECEIVED

9732

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MD.</u> COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>		d. STREET ADDRESS <u>1908 AUGUST DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>SADIE</u> Middle <u>JOSE PHINEAS</u> Last <u>STEWART</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 13, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESS MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	11. BIRTHPLACE (State or foreign country) <u>CHARLES COUNTY MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>JAMES M. PROCTOR</u>	
14. MOTHER'S MAIDEN NAME <u>IDA BENNEX</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>177</u>		17. INFORMANT <u>MR STANLEY HUGHES</u> Address <u>1908 AUGUST DRIVE SILVER SPRING</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PLURAL - FUSION - LTTT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA</u> DUE TO (c) <u>PRIMARY LTTT TUBERCULOSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 YRS</u> <u>2 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> to <u>1957</u> , that I last saw the deceased alive on <u>SEPT 4</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry W. Stewart</u> M.D.		ADDRESS (Street, city or town, state) <u>10011 Georgia Ave Silver Spring, Md.</u> DATE SIGNED <u>9/13/57</u>	
PHYSICIAN'S NAME (Type) <u>HENRY W. STEWART</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	24a. REC'D BY REGISTRAR <u>SEP 10 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>James P. [Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 10 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9620

CERTIFICATE OF DEATH

Reg. Dist. No.

09733

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>243 E Montg. Ave</u>		d. STREET ADDRESS <u>243 E. Montg. Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Wm R Stream</u>		4. DATE OF DEATH <u>Sept 8 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14-1895</u>
9. AGE (In years last birthday) <u>61 6/14</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u> IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VA</u>	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown Wm Stream</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lanham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>312-14-3292</u>	
17. INFORMANT <u>Marshall R. Stream</u>		Address <u>1025 Paul Dr. Rockville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis + moderate hypertension</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>Sept 4 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 8</u> , 19 <u>57</u> , and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm A. Linthicum</u> M.D.		ADDRESS (Street, city or town, state) <u>26 N. Summit Pl. Gaithersburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wm A. Linthicum</u>		DATE SIGNED <u>9/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>9/10/57</u>	24b. REGISTRAR'S SIGNATURE <u>Laurel Kragtop</u>

RECEIVED

BUREAU V. S.

SEP 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09734

Reg. Dist. No.

214

9733

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 3 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9505 Black Oak Cts.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 9505 Black Oak Cts.	
3. NAME OF (Type or print) Bennie Jeane Sublett		4. DATE OF DEATH Sept. 22, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1895
9. AGE (in years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months 1 Days 22 Hours 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Coveburg, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Bonnie Jean Attreed		Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 410.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart attacks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL OR CREMATION (Specify) BURIAL		22b. DATE THEREOF 9/26/57	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter B. Humphrey</i>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE SEP 24 1957 <i>Francis Patter</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 24 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9621

CERTIFICATE OF DEATH

09735

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1108 Great Oak Rd. Manor Club Estates				d. STREET ADDRESS 1108 Great Oak Rd. Manor Club Estates			
3. NAME OF DECEASED (Type or print) First James Middle Eugene Last Sullivan				4. DATE OF DEATH Month September Day 29 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1900	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Aeronautical Instrument Co.		11. BIRTHPLACE (State or foreign country) Franklin, New Hampshire	
13. FATHER'S NAME Dennis Sullivan				14. MOTHER'S MAIDEN NAME Alice Welch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 11				16. SOCIAL SECURITY NO. 215-36-4942		17. INFORMANT Dr. James R. Sullivan Address Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X Carcinomatosis DUE TO Carcinoma Symptomatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 18 mos 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) L			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/4 , 19 57 , to 9/29 , 19 57 , that I last saw the deceased alive on 9/28 , 19 57 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/30/57							
ACTUAL SIGNATURE Jacob W. Bird				M.D. Sandy Spring, Maryland			
PHYSICIAN'S NAME (Type) Jacob W. Bird				ADDRESS Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 10-2-57	
				24b. REGISTRAR'S SIGNATURE Laurel Kratoch			

BUREAU V. S.

OCT 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09736

9734 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				e. STREET ADDRESS Rt. #2			
3. NAME OF DECEASED (Type or print) First Elsie Middle Louise Last Thomas				4. DATE OF DEATH Month September Day 27 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5/27	
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS Hours 0 Min. 0		12. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel Kelley				14. MOTHER'S MAIDEN NAME Mary Anna Hodge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. or unknown) No				16. SOCIAL SECURITY NO. 101-10-1010		17. INFORMANT Hospital Record Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493x IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 18+ days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9/9/57 to 9/27/57 , 19 57 that I last saw the deceased alive on 9/27/57 , 19 57 , and that death occurred at 8:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				DATE SIGNED 9/28/57			
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.				ADDRESS Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/57		22c. NAME OF CEMETERY OR CREMATORY Sandy Spring		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swarden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR 3008	
24b. REGISTRAR'S SIGNATURE [Signature]							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

OCT 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09737

9735

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>				d. STREET ADDRESS <u>121 W. Church</u>			
3. NAME OF DECEASED (Type or print) <u>Emma Thompson</u>				4. DATE OF DEATH <u>Sept 16 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1871</u>		9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR <u>4</u> Months <u>6</u> Days <u>19</u> Hours <u>57</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Never employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Samuel I. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Ritter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Dr. Custis Jr. 1852 Columbia Rd. N.W. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis lungs & bone</u> DUE TO (c) <u>Carcinoma of Breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 months</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4?</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>9</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1957</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1949</u> to <u>Sept 16, 1957</u> that I last saw the deceased alive on <u>Sept 15, 1957</u> and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace H. Custis, Jr.</u>				ADDRESS (Street, city or town, state) <u>1852 Columbia Rd. N.W. Washington, D.C.</u>			
DATE SIGNED <u>9/16/57</u>							
PHYSICIAN'S NAME (Type) <u>Horace H. Custis, Jr., 1852 Columbia Rd. N.W., Washington, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 18, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Bailey + Son</u>				ADDRESS <u>1201 N. Market St. Frederick, Md.</u>		24a. REC'D BY REGISTRAR <u>Frances Potter</u>	
				DATE <u>17 Sept 1957</u>		24b. REGISTRAR'S SIGNATURE	

March 1917

W. H. C. C. C. C.
121 N. C. C. C.

X

BUREAU V. S.

SEP 20 1917

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9736

CERTIFICATE OF DEATH

09738 16
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Belvoir	
f. STREET ADDRESS 927A		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Winifred Middle Gay Last Tiller		4. DATE OF DEATH Month September Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1956
9. AGE (in years last birthday) 1 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Billie H. Tiller		14. MOTHER'S MAIDEN NAME Theda Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 071.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chylous Ascites and Diarrhea DUE TO (c) 2 mo PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coagential hypoplasia CEREBELLUM		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 23, 1957 , to September 13, 1957 , that I last saw the deceased alive on September 13, 1957 , and that death occurred at 4:08 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Nelson G. Richards M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Nelson G. Richards, M. D.		DATE SIGNED 9/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	17 Sept 1957	Big Stone Gap	BIG Stone GAP VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Golden Funeral Home		24. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 16 1957

RECEIVED

9737

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring- Rural		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD# 1				d. STREET ADDRESS RFD # 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARION DURY		First MARION		Middle DURY		Last WATSON		4. DATE OF DEATH Month Sept.		Day 8,	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1864		9. AGE (In years last birthday) yrs. 93		IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None- Artist		10b. KIND OF BUSINESS OR INDUSTRY Self Emp. None		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? US		IF UNDER 24 HRS Days 4		Hours Min.	
13. FATHER'S NAME William Watson						14. MOTHER'S MAIDEN NAME Elizabeth McDowell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Pat O'Neil-Item # 2		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Ischemia DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Cerebral Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 15 min. 15 min. Indef	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fr. of left femur											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rockville Md.		(County) (State)	
21. I certify that I attended the deceased from 2/13/1956 to 9/8/1957 , that I last saw the deceased alive on 9/8/1957 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above.											
ACTUAL SIGNATURE Stephen N. Jones						DATE SIGNED 9/9/57					
PHYSICIAN'S NAME (Type) Stephen N. Jones											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/9/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill				22d. LOCATION (City, town, or county) (State) Suitland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.						RECORDED BY REGISTRAR SEP 10 1957					
REGISTRAR'S SIGNATURE James Potter											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

75 10 1957

RECEIVED

9738

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE 16</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>26008 ERIE ST.</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>WEEKS</u> Last <u>WEEKS</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 7-1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WALTER NIXON GRAY</u>				14. MOTHER'S MAIDEN NAME <u>MARY RITTENHOUSE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>SON</u> Address <u>MR. FREDERICK WEEKS 2008 ERIE ST.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Thrombosis Anterior Descending Coronary Artery</u> DUE TO (c) <u>Atherosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ventricular aneurysm, left ventricular wall</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u> <u>several years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>November 1956</u> to <u>Sept 25, 1957</u> , that I last saw the deceased alive on <u>Sept 24, 1957</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Michael D. Haly M.D.</u>				ADDRESS (Street, city or town, state) <u>Washington D.C.</u> DATE SIGNED <u>Sept 25, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Michael D. Haly</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunmore</u>		22d. LOCATION (City, town, or county) <u>Dunmore</u> (State) <u>Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Lee's</u> ADDRESS <u>300 Fourth St. NE, Wash, D.C.</u>				24a. REC'D BY REGISTRAR <u>27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

SEP 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9622

CERTIFICATE OF DEATH

Reg. Dist. No.

0974813

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 W. Montgomery Avenue			d. STREET ADDRESS 301 W. Montgomery Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HELEN Middle TALBOTT Last WELSH			4. DATE OF DEATH Month SEPTEMBER Day 30 Year 19 57		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 16, 1883		9. AGE (In years last birthday) 74 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME H. Maurice Talbott			14. MOTHER'S MAIDEN NAME Cora Wilson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Barnard T. Welsh, 301 W. Montgomery Ave. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute coronary thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					
INTERVAL BETWEEN ONSET AND DEATH four weeks 2 1/2 months					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 15, 1957 to Sept. 30, 1957 , that I last saw the deceased alive on September 30, 1957 , and that death occurred at 1 P. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Wm. A. Linthicum M.D.			ADDRESS (Street, city or town, state) DATE SIGNED 26 N. Summit Ave., Baltimore, Md. 9/30/57		
PHYSICIAN'S NAME (Type) Wm. A. Linthicum					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/3/57		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	
				22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Humphrey			ADDRESS Silver Spring, Md.		
24a. REC'D BY REGISTRAR DATE 4 1957			24b. REGISTRAR'S SIGNATURE Arnold H. Taylor		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FRANKLIN V. S.

1901

RECEIVED
OCT 1 1901

9739

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE Montgomery		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Chase		c. LENGTH OF STAY IN lb 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Chase			
d. NAME & HOSPITAL (If not in hospital, give street address) 2715 Navarre Drive				d. STREET ADDRESS 2715 Navarre Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Leong		Middle Shue		Last Wen	
5. SEX F		6. COLOR OR RACE Chinese		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month 9 Day 21 Year 1957	
9. AGE (In years last birthday) yrs. 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY? China	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO		17. INFORMANT Betty Jean Wen		Address 8418 Donnybrook Dr. Chevy Chase, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive & Coronary Heart Disease DUE TO (c) Lymphosarcoma - Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 19 57 , to Sept 19 57 , that I last saw the deceased alive on 9/21 , 19 57 , and that death occurred at 7:35 p. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 9/21/57			
ACTUAL SIGNATURE Maurice Franks		M.D. 901 20th Ave, Wash DC					
PHYSICIAN'S NAME (Type) Maurice Franks							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/25/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 11th St. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR SEP 24 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. H.

SEP 04 1957

RECEIVED
SEP 04 1957

9616

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>32 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 17			
f. STREET ADDRESS <u>7132-Carroll Ave.</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>(no middle name)</u> Middle <u>Westberg</u> Last				4. DATE OF DEATH <u>Sept.</u> Month <u>1</u> Day <u>1957</u> Year			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Sweden/Denmark</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>Sven Andersen</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Hansen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Wash. San. & Hosp. Records</u> Address							
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Gall Bladder with Metastasis</u> DUE TO (b) <u>Hypostatic Pneumonia</u> DUE TO (c) <u>Hypostatic Pneumonia</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>Apr 1957</u> <u>Aug 30 1957</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/31/1957</u> to <u>9/1/1957</u> , that I last saw the deceased alive on <u>8/31/1957</u> , and that death occurred at <u>8:10 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard T. Morse</u>				ADDRESS (Street, city or town, state) <u>7030 Carroll Ave Takoma Park Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>HOWARD T. MORSE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick - Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Miller</u> ADDRESS <u>254 Carroll St D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Hall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 5 1957
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9740 CERTIFICATE OF DEATH

09743

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7945 Old Georgetown Road</u>				d. STREET ADDRESS <u>7945 Old Georgetown Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>KATE</u> Middle <u>WHEELER</u> Last <u>WHEELER</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1957</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/2/1870</u>		9. AGE (In years last birthday) <u>86</u> yrs <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS</td> </tr> <tr> <td>Months <u>11</u></td> <td>Days <u>18</u></td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months <u>11</u>	Days <u>18</u>	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS															
Months <u>11</u>	Days <u>18</u>	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Alexandria Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Brooks</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mrs. Baxter</u> Address <u>same as Item # 2d</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Bronchial Pneumonia.</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>10 Days.</u> <u>10 yr</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>18 Aug.</u> <u>1957</u> , to <u>20 Sep.</u> <u>1957</u> , that I last saw the deceased alive on <u>15 Sept</u> <u>1957</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7936 Georgetown Rd Bethesda 14 Md.</u> DATE SIGNED <u>20 Sept 1957</u>																	
ACTUAL SIGNATURE <u>John G. Ball</u>				PHYSICIAN'S NAME (Type) <u>John G. Ball</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>				22b. DATE THEREOF <u>9/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Private</u>		22d. LOCATION (City, town, or county) (State) <u>Spotsylvania County, Va</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>9-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Basia M. Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 4 1957

RECEIVED

9741

CERTIFICATE OF DEATH

09744

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mathias	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) First Lula Middle Belle Last Whetzel		4. DATE OF DEATH Month September Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1908
9. AGE (In years last birthday) 49 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Alice Feathers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ureteral obstruction and hydrocephalus DUE TO (c) Carcinoma of Cervix INTERVAL BETWEEN ONSET AND DEATH 1 month 1-3 mos 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ileovaginal Fistula			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19, 1957 , to September 2, 1957 , that I last saw the deceased alive on September 2, 1957 , and that death occurred at 8:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/2/57			
ACTUAL SIGNATURE Robert B. Couch M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) ROBERT B. COUCH			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/5/57	Jenkins Chapel Cem	Mathias, W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md.	24a. REC'D BY REGISTRAR DATE 9-4-57
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 3 1957

RECEIVED

9742

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 4534 Avondale St.	
3. NAME OF DECEASED (Type or print) First Jetta Middle Whitney Last Whitney		4. DATE OF DEATH Month Sept Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1878
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months 7 Days 9 Hours 15 Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lawrence Sivertsen	
14. MOTHER'S MAIDEN NAME Baroline		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT Millie F. Whitney Address 4534 Avondale St Bethesda, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.1 Congestive heart failure DUE TO (b) Cerebral Vascular accident DUE TO (c) 9 wks			INTERVAL BETWEEN ONSET AND DEATH 9 wks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 7-1-1957 to 7-21-1957 that I last saw the deceased alive on 7-21-1957 and that death occurred at 4:45 AM from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) 615 W. Montgomery Ave Rockville, Md.		DATE SIGNED 9/1/57	
ACTUAL SIGNATURE Wm. G. Hall M.D.		PHYSICIAN'S NAME (Type) Wm. G. Hall	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/57	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS 4534 Avondale St Bethesda, Md.	
24a. REC'D BY REGISTRAR 9-7-57		24b. REGISTRAR'S SIGNATURE Joseph M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

SEP 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9743

CERTIFICATE OF DEATH

09746

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>(District of Columbia)</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN TB <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>1005 County Road, S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Althea</u> Middle <u>Florence</u> Last <u>WILLIAMS</u>				4. DATE DEATH Month <u>September</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 March 1897</u>	
9. AGE (In years last birthday) <u>60 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Steven DUNINGTON</u>				14. MOTHER'S MAIDEN NAME <u>Barbara (Last Name Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Official Navy Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of anterior cerebral artery</u> X DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u> <u>unburned</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 August</u> , 19 <u>57</u> , to <u>13 Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert G. Galbraith, Jr.</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Galbraith, Jr., Lt., MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers, 517 11th St., S.E. Washington, D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>9-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Farrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 17 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9744

CERTIFICATE OF DEATH

Reg. Dist. No.

09742

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Loudon	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville---Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lucketts---Rural	
c. LENGTH OF STAY IN 1b 13 mth.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First BUCK Middle WILLIAMS Last		4. DATE OF DEATH September Month 9 Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880-?
9. AGE (In years last birthday) 77 ? yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Leroy Cooper---Poolesville R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic poisoning 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatic malignancy DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Aug. 1957 to 1 Sept. 1957 , that I last saw the deceased alive on 29 Aug. 1957 , and that death occurred at 7:10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Fawcett M.D.		ADDRESS (Street, city or town, state) P.O. Bay, Maryland DATE SIGNED 9/2/57	
PHYSICIAN'S NAME (Type) JOHN G. FAWCETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/4/57	22c. NAME OF CEMETERY OR CREMATORY Methodist	22d. LOCATION (City, town, or county) (State) Lucketts, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton ADDRESS Barrenville, Md		24a. REC'D BY REGISTRAR DATE 9/4/57	24b. REGISTRAR'S SIGNATURE Charles W. Elgin

BUREAU V. E.

SEP 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9745

CERTIFICATE OF DEATH

09749217
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.		e. STREET ADDRESS Dawson Avenue	
3. NAME OF DECEASED (Type or print) First Darrell Middle Eugene Last Wilson		4. DATE OF DEATH Month September Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/57
9. AGE (In years last birthday) 5 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 5 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Hicks Wilson		14. MOTHER'S MAIDEN NAME Eva June Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mother	
17. INFORMANT Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Heart Disease, Trauma 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Complete Transposition of Aorta and Pulmonary Artery DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE G. F. Mondore, M. D.			
PHYSICIAN'S NAME (Type) G. F. Mondore, M. D. Damascus, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-5-1957	
22c. NAME OF CEMETERY OR CREMATORY Prospect		22d. LOCATION (City, town, or county) (State) Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz		24. REC'D BY REGISTRAR SEP 6 1957	
ADDRESS Winfield, Md.		24b. REGISTRAR'S SIGNATURE Arthur Lawless	

2073324xv7

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The text is faint and mostly illegible.

BUREAU V. S.

SEP 6 1957

RECEIVED

9746

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE New Mexico b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 18 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Albuquerque				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			
d. STREET ADDRESS 318 Mulberry, S. E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Isabel Middle Bessie Last Yoder				4. DATE OF DEATH Month September Day 12, Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1929	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Mexico	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Raymond Olguin				14. MOTHER'S MAIDEN NAME Ania Chaves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 525-48-7911		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post-operative hemorrhage (c) Pulmonic stenosis, ventricular and interatrial septal defect INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours Congenital							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 25, 1957 , to September 12, 1957 , that I last saw the deceased alive on September 12, 1957 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/12/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE James A. McFarland M.D.				PHYSICIAN'S NAME (Type) /s/ James A. McFarland, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit				22b. DATE THEREOF 9/12/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	
22d. LOCATION (City, town, or county) (State) Bernandillo Co. New Mexico							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR OCT 8 1957			
24b. REGISTRAR'S SIGNATURE Bessie Thompson							

MEDICAL CERTIFICATION

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 8 1957

RECEIVED